A qualitative exploration of therapists' experiences as clients who prematurely terminated their therapy in England

Thesis submitted in accordance with the requirements of the University of Chester for the degree of Doctor of Professional Studies in Counselling and Psychotherapy Studies

by Christine Frances Bonsmann

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Declaration

I declare that the material being presented for examination is my own work and has not been submitted for an award of this or another Higher Education Institution.

Acknowledgements

I am grateful to all participants for their contributions and time. I hope I have done justice to your experiences.

I am grateful to my research supervisors, Reverend Professor Peter Gubi and Dr Andrew Reeves, for their guidance, support, and kindness, as well as to others who have contributed to my learning, particularly Professor William West.

I am also grateful to my family for understanding my many absences over the past six years.

Abstract

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Christine Bonsmann

This qualitative study explored experiences of prematurely terminating adult individual therapy from the perspectives of therapists as clients in England. The aims of the study were to gain an overview of the experience of prematurely terminating therapy; to understand the experience of dissatisfaction when this is given as a reason for prematurely terminating therapy; and to inform and thus help improve practice. Rates of premature termination from counselling and psychotherapy remain high despite a considerable body of research into possible predictors of this phenomenon. Few studies have explored clients' experiences of premature termination in depth. Clients often report dissatisfaction as a reason for premature termination, and this experience is under-researched. From practitioners' perspectives, little is known about indicators of dissatisfaction, and how to manage premature termination if it occurs.

The study was conducted in two stages. The purposeful sample were therapists who, as clients, prematurely terminated personal therapy after attending at least two sessions. Participants self-selected as having prematurely terminated therapy. Stage one used an online qualitative survey to gain an overview of participants' experiences of premature termination, and the 40 usable responses were analysed inductively using thematic analysis. The survey was used to recruit participants for stage two. In stage two, six semi-structured interviews were carried out with participants who had prematurely terminated therapy for reasons of dissatisfaction. The data were analysed using interpretative phenomenological analysis. Overall, the major themes created were: feeling dissatisfied; client becomes unable to continue therapy; and communication about the premature termination.

The findings confirm the importance of the working alliance in therapy, and illuminate how the alliance failed to develop in experiences of dissatisfaction. It is argued that understanding clients' experiences could enable practitioners to recognise the presence of dissatisfaction, and adapt therapy, if appropriate, to minimise avoidable premature termination. The need for therapy to 'add value' was also identified. The findings indicate a failure by some therapists to act in a relational way *when* clients prematurely terminated therapy, thereby disrupting the dominant discourse about the importance of the therapeutic relationship. Clients' needs at the point of premature termination were identified.

The findings of this study are not generalisable but may be transferable. The study concludes that therapists' management of how therapy ends is just as important as the management of how it begins, *regardless* of how it ends. This has implications for practice and training. Areas for further research are identified.

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List of abbreviations

BACP British Association for Counselling & Psychotherapy

BPS	British Psychological Society
EAP	Employee Assistance Programme
EMDR	Eye Movement Desensitisation and Reprocessing
IAPT	Improving Access to Psychological Therapies
IP	Internet Protocol
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCR	Outcome Rating Scale
OQ-45	Outcome Questionnaire-45
PIS	Participant Information Sheet
PT	Premature Termination
SRS	Session Rating Scale

Chapter 1: Introduction

This thesis explores clients' experiences of prematurely terminating adult individual counselling or psychotherapy, to inform and thus help improve practice.

1.1 Background

In 2006, the UK Government introduced the Improving Access to Psychological Therapies (IAPT) programme in order to make psychological therapy services widely available (Department of Health, 2007). The focus on an evidence-based agenda and the influence of the National Institute for Health and Care Excellence (NICE) guidelines on service provision in the National Health Service (NHS), as well as the measurement of clients' outcomes, had a trickle-down effect on many practitioners working in the field of psychological therapies. Although it had previously been suggested that practitioners have little interest in research (Morrow-Bradley & Elliott, 1986), a shift took place following the introduction of IAPT which translated into an emphasis on developing a culture of research in counselling and psychotherapy (Cooper, 2008).

The value of including clients' views to inform theory and practice has been recognised (Clarke, Rees, & Hardy, 2004), although some argue that clients accounts are unreliable (Macran, Ross, Hardy, & Shapiro, 1999). According to Elliott and James (1989), the meaning of therapy can only be discovered by referring to clients, and involving clients in research acknowledges that therapy can be collaborative (Dallos & Vetere, 2005). There are, however, ethical considerations connected with involving clients in process research relating to the potential to intrude on the therapy (McLeod, 1990). Despite this, process research has made major contributions to understanding clients' experiences in therapy, for example regarding clients' deference (Rennie, 1994). With respect to outcome research, some researchers believe that clients can benefit from being involved in research (Etherington, 2007), and it is argued that understanding clients' lasting and significant experiences is of value to inform practice (Clarke et al., 2004).

A significant amount of research has been carried out to establish the benefit of therapy, and an estimated success rate of 67% has been reported (Lambert, 2013). Bearing this in mind, it is suggested that "the greatest potential for improving the

effectiveness of psychotherapy lies in addressing the issue of premature termination" (Swift & Greenberg, 2015, p. 4). A study carried out in the UK to review the effectiveness of a NHS primary care mental health service found that only one in five referred patients finish treatment (Gilbert, Barkham, Richards, & Cameron, 2005). This finding is consistent with a meta-analysis of over 600 studies which reported a dropout rate of approximately 20% (Swift & Greenberg, 2012).

There are a number of reasons why premature termination (PT) is a matter of concern. Barrett, Chua, Crits-Christoph, Gibbins, Casiano, and Thompson (2008) suggest that PT results in the inefficient utilisation of resources, waiting lists, and a potential deterioration in symptoms. Dropout is associated with poor recovery rates (Hansen, Lambert, & Forman, 2002). If a client drops out of therapy before achieving improvement, this may indicate treatment failure (Watson, 2011), although separating the impact on the client of therapy from other life events is complex (Mash & Hunsley, 1993). Even if a client reports environmental reasons for leaving therapy, this does not necessarily mean that this is why the client is leaving, given the research indicating that clients hide negative responses from their therapists (Hill, Thompson, & Corbett, 1992). Therefore, the extent of the problem may be underestimated. From the client's perspective, dropping out of therapy deprives them of closure and a worked-through ending (Joyce, Piper, Ogrodniczuk, & Klein, 2007). Clients may lose hope that they can be helped (Sherman & Anderson, 1987), and/or experience negative feelings (Adler, 2013; Orcutt, 2013; Dickson, 2015). If a client drops out of therapy, this could also impact on significant others in the client's life (Swift, Greenberg, Whipple, & Kominiak, 2012). Therapists are also reported to be affected by client dropout, and it has been found to impact on their self-esteem (Ogrodniczuk, Joyce, & Piper, 2005).

Alongside the negative consequences of dropout is a counterargument, which could see dropout as a potential opportunity for growth (Dickson, 2015), or an expression of the client's power in therapy (Orcutt, 2013). The ending stage of therapy is considered an important stage by therapists to reflect on the work of therapy, to consider how to sustain and extend change, and to achieve closure (Horton, 2012). PT by clients prevents this process from happening. It may be that clients simply see things differently and do not feel the need to terminate according to 'best practice'. Alternatively, PT may be a sign that something has arrested the therapy process.

PT is poorly understood by therapists. The reasons given by therapists and clients for PT rarely converge (Hunsley, Aubry, Verstervelt, & Vito, 1999). Historically, much research has tried to predict the client factors associated with PT. Despite this, dropout rates remain high (Swift & Greenberg, 2015). This could suggest that it is not possible to reduce rates further, and that dropout reflects that 'therapy is not for everyone', or that it is part of a learning curve for some clients (Wilson & Sperlinger, 2004). Much existing research involving clients has used quantitative surveys, reviews of clients' files, or follow-up interviews, lacking in rich data, asking clients their reasons for PT rather than exploring their experiences (Knox, Adrians, Everson, Hess, Hill, & Crook-Lyon, 2011). Some recent unpublished theses, however, have investigated PT from clients' perspectives (Adler, 2013; Chatfield, 2013; Dickson, 2015; Orcutt, 2013), and are included in the review in Chapter 2. Dissatisfaction has been consistently reported as a reason for PT by clients (Swift & Greenberg, 2015), and while Adler's (2013) study explored clients' experiences of dissatisfaction, it was restricted to psychoanalysis in the USA. Little research has explored clients' experiences of PT in depth across a range of therapies outside the USA (see section 2.2.2), and dissatisfaction in PT is under-researched.

1.2 Purpose of the study

While the research searching for 'predictors' of PT has failed to reach any conclusive results, the research about clients' reasons for PT has been largely consistent. Over time, three main reasons for dropout have been identified by clients: improvement; environmental issues; and dissatisfaction (Swift & Greenberg, 2015). Unfortunately, knowing the reason for PT does not illuminate the client's experience in sufficient depth to understand how/if practice could be changed. This study seeks to build on the small corpus of studies exploring clients' experiences. This thesis will consider the importance of understanding clients' experiences of prematurely terminating therapy, particularly when dissatisfaction is present. This research could be valuable because it could help therapists to gain insights into the client's process before, during, and after PT. This could inform therapists about ways to meet clients' needs. If therapists are evaluated based on their outcomes, including dropout rates (Parry, 2015), then it is suggested that it is necessary to gain a better understanding of clients' experiences of PT. It would be valuable to understand how dissatisfaction manifests in therapy so that therapists could gain awareness of possible signs of

dissatisfaction. This study also offers the opportunity for therapists to consider how to respond to clients who prematurely terminate therapy as no existing research specifically explores clients' experiences of this aspect of PT. In addition, the findings could encourage clients to discuss any concerns with therapists about how they are experiencing therapy.

1.3 Research question and aims of the study

This study seeks to answer the question: *What is the experience of clients who prematurely terminate therapy?* The aims of the research are:

- To gain an overview of the experience of clients who prematurely terminate therapy.
- To understand the experience of dissatisfaction when this is given as a reason for prematurely terminating therapy.
- To inform and thus help improve practice.

In order to build on the existing research about clients' experiences of PT, a qualitative research design was considered appropriate, informed by a transactional and subjectivist epistemology (Ponterotto, 2005). The research was carried out in two stages, and this design was emergent because it was difficult to recruit participants (see section 3.3). Stage one used an online qualitative survey to gain an overview of clients' experiences of PT. The survey data provided insights into this experience from 40 participants, and was used to recruit participants for stage two of the research. Stage two involved interviewing six participants to understand their experience of dissatisfaction when this was given as a reason for PT.

1.4 Terminology

1.4.1 Defining premature termination

The debates about the definition of PT are considered in section 2.1.1. In this study, PT is defined as leaving therapy before participants' goals were met, and attendance at a minimum of two sessions of therapy was required. This decision was based on the inconsistency in the literature about the definition of PT (Swift & Greenberg, 2015). This definition recognises that some clients can be helped by few sessions (Barkham, Shapiro, Hardy, & Rees, 1999), and takes into account the absence of a significant relationship between duration in therapy and reasons for PT (Anderson, 2015). It excludes attrition following an initial assessment session, although it is

recognised that assessments can extend over several sessions, and allowed participants to self-select as having prematurely terminated therapy (Orcutt, 2013).

1.4.2 Use of terminology throughout the thesis

Throughout the thesis the term 'therapy' is used to include counselling and psychotherapy, which is consistent with guidelines in the literature (Cooper, 2008). The debate about differences between counselling and psychotherapy is beyond the scope of this research. The term 'therapist' is used to include counsellor and psychotherapist. The terms 'premature termination' and 'dropout' are used interchangeably, as are the terms 'clients' and 'patients'. Clients who prematurely terminate therapy are called 'premature terminators' and clients who remain in therapy are called 'remainers' to avoid lengthy repetitions. In stage two of the research, participants were not offered a definition of 'dissatisfaction', to avoid imposing a conceptual framework on participants and to allow them to self-select as being dissatisfied.

1.5 Positioning statement

There were a number of reasons for undertaking a Professional Doctorate. I am committed to my work as a Counsellor, and I found a previous research project I carried out interesting and informative for my practice. I presented and published this research, and received feedback that it was useful for practice. I wanted to pursue my interest in research, make a contribution to the therapy community, and inform my practice.

I offer the following to indicate my personal and professional interest in PT, as this is the lens through which I have carried out this research. It is considered to be important that the reader of qualitative research is informed about the researcher's position (Etherington, 2004). Throughout the process, I have adopted a reflexive stance but it is inevitable that 'who I am' has shaped all aspects of the research. This statement also helps me to remain aware of my potential impact on this research.

I believe in the value of therapy. It has helped me enormously. I understand that others do not share this view (Masson, 1997). I am interested in maximising the potential of therapy, trying to understand when it does not work for the client, and gaining insights which may mitigate the possibility of PT occurring unnecessarily. I see this stance as a critical part of my continuing professional development. PT is

often a private and emotional experience, and so opening up a conversation may go some way to understanding the impact of PT.

I work integratively as a Counsellor in private practice, and my core training was in the person-centred approach. I value clients' subjectivity, and this has influenced my preference towards constructivism. It was important that I allowed participants to self-select as having prematurely terminated therapy and that I allowed participants to decide what dissatisfaction was. My expectation was that participants would talk about their experience of the therapeutic relationship. My interest is in general processes that occur in therapy. In the past, I have worked in large psychological therapy services and a number of charities. Before training to become a Counsellor, I lived abroad for a number of years in various locations in the USA and Europe, and have moved many times. I have often felt homeless and without a secure base. Leaving and loss, and sometimes finding it too painful to say goodbye, are written all over my biography. These experiences have inevitably sensitised me to those who feel like an outsider, who feel they do not quite fit in, who sit on the margins, or who feel that they do not really belong here, wherever that 'here' may be. Sometimes these people are referred to as 'dropouts' by those who fail to understand their stories.

My first 'real' client failed to turn up for their session. A colleague offered, "don't worry, it's not about you. And even if you had started working with them and they didn't show up, it would never be about you". I found that remark surprising as a trainee and I still find it surprising 11 years later, the idea that the therapist could be considered to be so 'absent' from the therapeutic encounter. Over the years, I have witnessed and experienced the conflicting feelings PT can cause. I wonder about clients who prematurely terminate, and how they feel about their therapy experience. I never fail to reflect on the part I may have played if one of my clients prematurely terminates. I believe that gaining an understanding of clients' experiences of PT, particularly when they have experienced dissatisfaction, offers considerable potential to inform and thus help improve practice, and to consider how to manage this process. I feel uncomfortable hearing clients being referred to as 'dropouts' and being pathologised along the lines of 'well they would, wouldn't they'. That does not fit with my way of being a therapist.

I have also prematurely terminated therapy as a client, more than once, for reasons that I will not discuss here. Those stories do not belong solely to me. On occasion, I did not experience the way my PT was handled as helpful, and this has also informed my interest in this research. I am curious about how clients experience therapists' responses to PT, and believe that this is an important aspect of the experience of PT. It is an area I wrestle with professionally from time to time: 'what is the right thing to do?'

Other factors which could influence this research include that I am a white, British, middle-aged, middle-class female. I am aware that these descriptors obscure as much as they reveal. I live in a deprived area in England and try to be aware of the potential impact of 'who I am' in my practice. My hope is that I can achieve an awareness of the impact of 'who I am' in this research too. I intend to keep an ethical mind and heart throughout.

1.6 Structure of the thesis

Chapter 2 provides an overview of the literature about PT, and reviews the literature involving clients' experiences of PT. Theoretical frameworks which could be used to understand PT are also considered. Chapter 3 outlines the methodological choices and methods used to answer the research question. In Chapters 4 and 5 the findings of the research are presented. Chapter 6 presents a discussion of the findings in the light of the literature. Finally, Chapter 7 presents the conclusion, the limitations of the research, and considers how the research could be developed. The relevance of the research is tentatively offered, the original contribution to the field is identified, and a closing reflexive statement considers the impact this research has had on me.

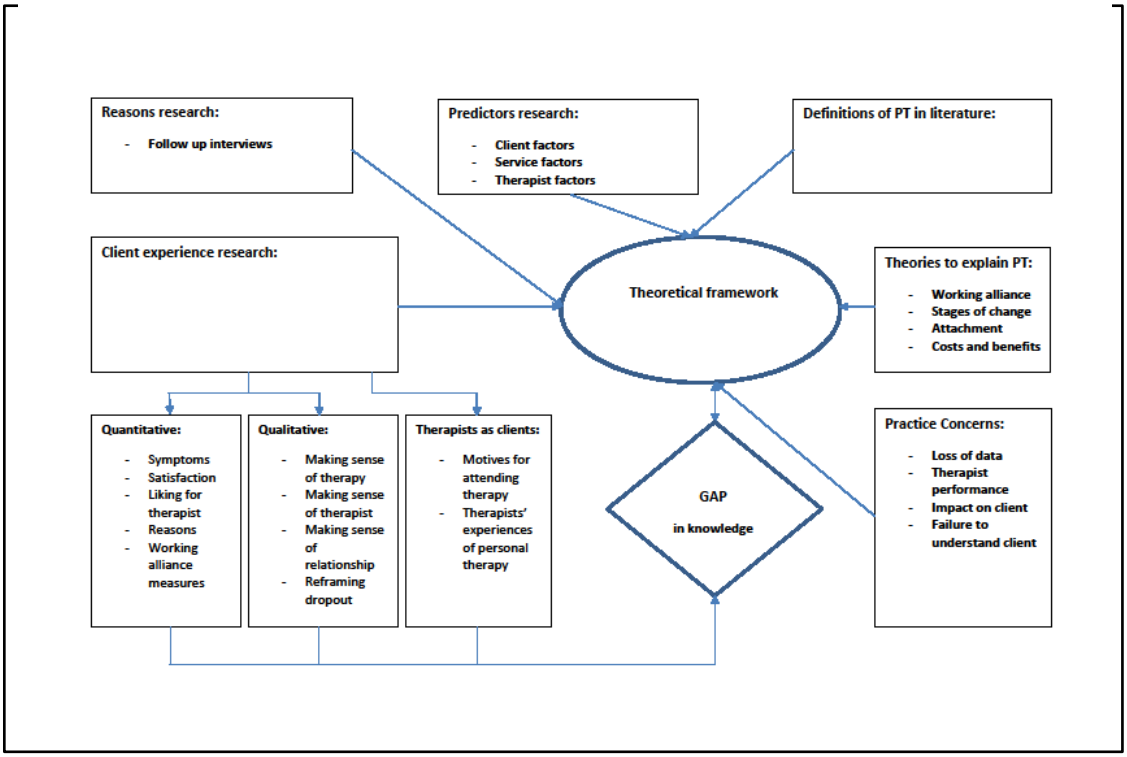
1.7 Summary

This chapter has introduced the background to the research, and the purpose, question, and aims have been presented. Terminology has been clarified, and a positioning statement has been included. The structure of the thesis has been outlined. The next chapter reviews the literature.

Chapter 2: Literature review

The purpose of this chapter is to contextualise the research within a theoretical framework (see Figure 1) which draws on the existing literature about PT, theories which may be used to explain PT, client experience studies, and practice concerns.

Figure 1: Theoretical framework informing study



This approach aims to provide a context for the research (Boote & Beile, 2005), provide a critical overview of what has already been done (Hart, 1998), and develop the argument for the need for further qualitative research in order to understand the experience of PT from the perspective of the client. In terms of providing an overview of the field, I have drawn on the reviews and meta-analyses of PT that have been carried out (see section 2.1). These reviews have been carried out in the USA. No comparable reviews were available in England. With respect to the research about clients' experiences of PT, very little research has been carried out in England. Of the 25 studies included in this review (see Table 1), 17 were carried out in the USA. These studies include unpublished theses (n=12) which have been taken into

consideration given the paucity of research in this area. The literature regarding the therapist as client has focused on studies carried out in England.

This chapter will consider the main debates in the literature about PT from therapy, and the key themes of the research involving clients will be identified to contextualise the research question: *What is the experience of clients who prematurely terminate therapy?* The review will focus on adult individual outpatient therapy, so the literature regarding child, couples, group, and family therapy has been excluded. A distinction is made between prospective clients who do not enter therapy, and clients who have attended therapy. The former are not considered to have dropped out and are excluded from this review, as are studies which focus on attrition following an initial assessment or first session.

Section 2.1 presents a brief overview of the literature about PT; section 2.2 presents a review of client studies; section 2.3 presents a review of the therapist as client; section 2.4 identifies area for concern; and section 2.5 concludes this chapter.

2.1 Overview of the literature about premature termination

A number of databases were searched using appropriate search terms (see Appendix 1), relevant papers were read, and references in papers were followed up. A number of reviews and meta-analyses of PT have been carried out. An early review of 362 studies spanning 20 years of research covering a wide range of settings found many contradictory reasons for PT, and the reviewers suggested involving clients in research to understand this phenomenon (Baekeland & Lundwall, 1975). A later review of PT from university counselling services also reported contradictory findings (Mennicke, Lent, & Burgoyne, 1988). Following on from Baekeland and Lundwall's (1975) work, a meta-analysis of 125 studies concluded that more complex variables, for example the interaction between the client and therapist, required exploration (Wierzbicki & Pekarik, 1993). The review by Reis and Brown (1999) including 30 years of research also reported highly contradictory findings, and suggested that therapists adapt treatment to suit clients. Finally, the most recent meta-analysis by Swift and Greenberg (2012) of 669 studies highlighted the need for consistency in the definition of dropout, and suggested collecting outcome measures at every session to ensure that information is available for all clients.

2.1.1 The extent of premature termination

A number of terms have been used to describe PT including dropout, attrition, and unilateral termination. Considerable debate exists about the definition of PT, which means that comparing studies is difficult (Barrett et al., 2008). PT has been defined in several ways, including:

- non-attendance at a scheduled session;
- therapist judgement;
- failure to complete a treatment protocol;
- failure to attend a set number of sessions; and
- failure by the client to achieve a clinically significant improvement.

Each definition has limitations (Swift & Greenberg, 2015). Non-attendance at a scheduled session may misclassify clients who are terminating appropriately, albeit unilaterally. While it is suggested that 'therapist judgment' is preferable to 'number of sessions attended', there are reliability issues with this definition (Reis & Brown, 1999). Further, research indicates that therapists can be poor at assessing clients' negative experiences (Hunsley et al., 1999). Failure to complete a treatment protocol restricts applicability to settings that follow a specific protocol. A definition based on attendance at a set number of sessions is consistent with the recommendations in the dose-response[1] literature (Hansen et al., 2002), although researchers have used different numbers of sessions. Reis and Brown (1999) suggested that "even if all researchers adopted the same number of sessions as the criterion for dropout, results would still be inconsistent, as duration is not necessarily related to dropout status" (p. 24). Confusion is caused by a failure to distinguish between early termination and PT. Pekarik (1985) has insisted that early terminators are not necessarily 'dropouts' because their early termination may be appropriate. Finally, while the clinically significant improvement definition links outcome to termination classification, it necessitates completing questionnaires at every session (Hatchett & Park, 2003). Regardless of definition, "the concept of dropout assumes unilateral client termination or termination against therapist advice" (Pekarik, 1985, p. 86).

Differences in definitions influence the reported rate of dropout. While Wierzbicki and Pekarik (1993) reported a dropout rate of 46.86% across a wide range of treatments, a lower rate was found if the definition of non-attendance at a scheduled session was used. More recently, the meta-analysis by Swift and Greenberg (2012)

1The dose-response considers how many sessions of therapy are required for a client to improve.

reported a dropout rate of 19.97%, also moderated by definition of dropout. However, the degree of heterogeneity in their meta-analysis was significant. In their study, a definition using therapist judgment yielded a rate of 37.6% compared to 18.3% for a duration-based definition, and 18.4% for a treatment protocol based definition. In later work, they suggested that clinically significant change or improvement be used to define dropout because "these operationalizations best fit with the definition of dropout as discontinuing therapy before improving from the problems that led one to seek treatment" (Swift & Greenberg, 2015, p. 27).

It has been suggested that therapists may consider clients who unilaterally terminate to be treatment failures (Reis & Brown, 1999). This is not supported in the literature. Swift and Greenberg (2015) summarised a number of clients' reports of the three most commonly reported reasons for prematurely terminating therapy as follows:

- improvement was reported in between 13% and 37% of cases;
- environmental factors were reported in between 40% and 55% of cases; and
- dissatisfaction was reported in between 22% and 46.7% of cases.

All studies included in their summary were based on experiences within a particular service. It is possible that such studies are limited because clients may be unwilling to reveal their reasons for termination (Moras, 1985). In contrast, a recent online survey eliciting clients' (n=157) reasons for PT from various settings identified 'lack of motivation for therapy' rather than 'improvement' as the third most commonly occurring reason for termination, after dissatisfaction and environmental factors (Anderson, 2015). More research is needed to understand the implications of this study.

2.1.2 Strategies to reduce dropout

It is useful to consider what steps have been taken to reduce client dropout. Ogrodniczuk et al. (2005) identified nine strategies to address treatment dropout: preparation before therapy begins; selection of patients; time-limited contracts; negotiating treatment; case management; reminders for appointments; enhancing motivation; therapeutic alliance development; and enabling affect expression. The research into the effectiveness of these strategies has not yielded consistent results. A meta-analysis of 31 randomized controlled trials which tested the effectiveness of

interventions to prevent dropout found a moderate level of effectiveness (Oldham, Kellett, Miles, & Sheeran, 2012). There is some evidence that providing information to clients about the length of therapy before therapy starts reduces dropout. For example, a study by Swift and Callahan (2011) randomized clients (n=63) into control (n=32) and education (n=31) groups, and found that the education group attended more sessions and were more likely to complete therapy. The education provided was based on the dose-effect literature and dropout was defined using therapist judgment, both of which rely on therapists' views. Similarly, Reis and Brown's (2006) study, which tested using instructional material with 125 clients, found that this was effective in preventing dropout. Overall, while some prevention strategies have some utility in addressing how therapy *could* be, they cannot legislate for what emerges once therapy begins.

2.1.3 Theories to explain dropout

There is some debate about the theories informing dropout. Across all therapies, the common factors[2] of therapy have been found to account for approximately 30% of the variance in outcome (Lambert, 1992). Rogers' (1957) research about the core conditions of therapy: accurate empathy; unconditional positive regard; and congruence, has informed this area of research. The common factors include the relationship between the client and therapist. Variation exists among terminology used, and Lambert and Barley (2001) stated,

> in discussing client-therapist relationship factors, it is difficult to conceptually differentiate between therapist variables (e.g., interpersonal style, therapist attributes), facilitative conditions (empathy, warmth, congruence), and the therapeutic alliance. These concepts are not mutually exclusive or distinct, but are interdependent and overlapping. (p. 358)

The terms therapeutic alliance and working alliance are used interchangeably (Lambert & Barley, 2001), and refer to the dimension of the therapist-client

2Client outcome is reported to be distributed among four therapeutic factors. These factors, with the percentage of outcome variance shown in brackets, are: expectancy (15%); extratherapeutic change (40%); techniques (15%); and common factors (30%) (Lambert & Barley, 2001). The common factors refer to the aspects of therapy that are shared across all modalities of therapy. Lambert and Barley (2001) assert that "among those factors most closely associated with therapist activity, the common factors, or client-therapist relationship factors, are most significant in contributing to positive therapy outcome" (p. 358).

relationship which acknowledges the input of the client. Bordin (1979) identified the constituents of the working alliance as goal agreement, tasks, and bonds. The goals are the mutually agreed objectives for therapy, the tasks are the way these goals are worked on in the therapy sessions, and the bond is the working relationship between the therapist and client. Bordin (1979) theorised that unilateral client termination reflects a poor alliance. Evidence indicates that a good therapeutic alliance is associated with a positive outcome (Horvath & Symonds, 1991). A meta-analytic review of 11 studies confirmed a moderately strong connection between the therapeutic alliance and dropout (Sharf, Primavera, & Diener, 2010). The number of participants included in the studies ranged from 20 to 451. They reported that a weaker therapeutic alliance meant that clients were more likely to drop out of therapy. Unfortunately, clients and therapists report different views about the alliance (Castonguay, Constantino, & Holtforth, 2006; Johansson & Eklund, 2006). Castonguay et al. (2006) summarised decades of research about the alliance and cautioned against therapists overestimating their own view of how therapy is going. They suggested that monitoring clients' perceptions of the alliance could alert therapists to ruptures which need addressing. Johansson and Eklund's (2006) study (n=122) found that the working alliance, as assessed by clients, was significantly lower for clients who dropped out of therapy. It is recognised that the working alliance is crucial in the early stages of therapy, and it is foregrounded again at times when the client is experiencing difficulties (Gelso & Carter, 1994). The ability to develop a strong alliance and repair ruptures is considered to be essential in minimising PT from therapy (Rhodes, Hill, Thompson, & Elliott, 1994). While therapist-administered alliance measures may be useful to evaluate whether the formation of the working alliance is on track, the use raises questions concerning clients deferring to therapists (Rennie, 1994) and hiding negative opinions (Hill, Thompson, Cogar, & Denman, 1993).

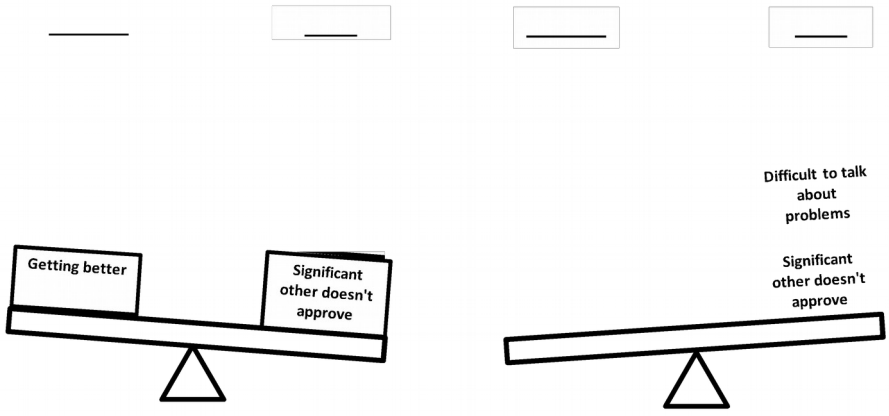
Another theory which could be used to understand how clients engage with therapy is the transtheoretical model (Prochaska, DiClemente, & Norcross, 1992). This model identifies five stages of the change process. The first stage is precontemplation, followed by contemplation, preparation, action, and maintenance. The therapist's role is to identify the client's stage of change and develop interventions to match this. A meta-analysis of 39 studies involving 8,238 clients

found the stages of change to be useful in predicting PT (Norcross, Krebs, & Prochaska, 2011). The acceptance that a client decides not to remain in therapy acknowledges that clients can choose not to be 'fully-functioning' persons (Mearns & Thorne, 2013).

Attachment theory (Bowlby, 1988) could also be used to inform understanding of dropout. Bowlby (1988) positioned the therapist as someone offering a secure base to a client, which enables the client to work through their problems in therapy. This theory may be limited to explaining the PT of clients who do not possess a secure attachment, or the impact of the therapist's attachment style on therapy.

Another way to understand PT is by using Swift and Greenberg's (2015) theory, which is "based on perceived and anticipated costs and benefits" (p. 30). It takes into account a range of 'costs' associated with attending therapy including financial, the intrinsic difficulty of a process that involves talking about problems, and triangulation[3] issues. The client compares these costs to the perceived benefits of remaining in therapy (see Figure 2).

Figure 2: Conceptualisation of clients' premature termination



Source: Swift and Greenberg (2015, p. 30).

This theory fails to recognise that clients are not always fully aware of all factors involved in a decision to terminate (Westmacott & Hunsley, 2010).

2.1.4 Factors influencing dropout

3Triangulation refers to the dilemma a client faces when they feel they need to make a choice between the therapist and a person outside of therapy (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996).

Several researchers have tried to discover predictors of dropout (Keijsers, Kampman, & Hoogduin, 2001; Lampropoulos, Schneider, & Spengler, 2009). These are now briefly discussed.

2.1.4.1 Client factors

Historically, a considerable amount of research has been carried out to try and identify client variables associated with PT. Sperry (1985) suggests that a 'defaulter personality' has yet to be discovered. In terms of demographic variables, Wierzbicki and Pekarik (1993) associated racial status, education level, and socio-economic status with dropout. These findings were consistent with an earlier review which also associated younger and female clients with PT (Baekeland & Lundwall, 1975). The most recent meta-analysis by Swift and Greenberg (2012) included studies between July 1990 and June 2010, and reported a different picture as only being younger was found to be consistently correlated with PT. More recently, an online survey involving clients (n=157) who dropped out of therapy associated being female and non-heterosexual with PT (Anderson, 2015).

Client diagnoses of personality disorder and eating disorder have been found to be consistent predictors of PT (Swift & Greenberg, 2012). A previous experience of dropping out of therapy (Baekeland & Lundwall, 1975), as well as attitudes towards treatment (Edlund, Wang, Berglund, Katz, Lin, & Kessler, 2002), have also been found to influence dropout. On the other hand, clients who drop out are seen as assertive and discerning and have been regarded as "shopping around for a therapy that suits them" (Wilson & Sperlinger, 2004, p. 220).

The search for client characteristics associated with dropout raises questions about the purpose of such research. While it is recognised that knowledge about particular client characteristics may be helpful to develop strategies to reduce attrition, as far as that is possible, such knowledge may also lead to countertransferential feelings. In a small study comparing premature terminators (n=20) to remainers (n=20), countertransference was reported as a significant predictor of dropout (Frayn, 1992). In summary, premature terminators have been found to be a heterogeneous group, and the findings from the research exploring client factors are inconsistent (Bohart & Wade, 2013).

2.1.4.2 Service and therapist factors

With respect to service factors, the length of time on the waiting list does not seem to be related to dropout (Freund, Russell, & Schweitzer, 1991), and a higher rate of dropout has been associated with training settings (Aubuchon-Endsley & Callahan, 2009; Swift & Greenberg, 2012). A difficulty in university settings is that therapy is sometimes terminated at semester end (Fray, 2000), or because of academic demands (April & Nicholas, 1997). Lower dropout rates have been reported in clinics that match clients and therapists on ethnicity (Sue, 1998), although a meta-analysis of seven studies on ethnic matching did not support this finding after session one (Maramba & Nagayama Hall, 2002). With respect to type of therapy provided, time-limited and manualised therapy are associated with low dropout rates, but theoretical orientation has not been associated with dropout (Swift & Greenberg, 2012). Garfield (1997) acknowledged that the therapist's contribution to the therapeutic process has received little attention. With respect to therapist variables, Swift and Greenberg (2012) associated low rates of dropout with experienced therapists.

2.1.4.3 The therapeutic process

It has been recognised that it is necessary to explore what happens in therapy (Reis & Brown, 1999). In their review, Barrett et al. (2008) identified clients' perceptions of therapist expertise, goal agreement, and a failure to meet clients' expectations as influencing dropout. Incorporating clients' preferences for treatment may reduce the incidence of dropout, and this is consistent across a number of client characteristics, for example age, gender, ethnicity and education (Swift, Callahan, Ivanovic, & Kominiak, 2013). Topic agreement is related to expectations, and two small quantitative studies by Tracey (1986) (study 1 n=6 dyads; study 2 n=18 dyads) at different university services found that a low level of topic agreement was present in PT.

The number of sessions that clients expect to attend is particularly relevant to PT, and has been found to influence the number of sessions actually attended (Pekarik & Wierzbicki, 1986). This finding has been subsequently replicated (Mueller & Pekarik, 2000). A later study by Reis and Brown (2006) found that even when treatment duration was elicited and contracted, the rate of dropout was not reduced. The debate about the number of sessions required is not restricted to client-therapist differences. The dose-response literature, based on clinical trials, has identified about 12.7 sessions as being necessary to achieve improvement in 50% of cases

(Hansen et al., 2002), whereas other studies have recognised a significant level of change for clients with subsyndromal depression following two-plus-one sessions (Barkham et al., 1999).

In summary, although the research about the factors which influence dropout is interesting, it is inconsistent because of a number of methodological problems, and fails to consider clients' experiences (Swift & Greenberg, 2012).

2.2 Client studies

2.2.1 Quantitative studies

Quantitative methods to assess aspects of clients' experiences have included surveys (Denner & Haplrin, 1974; Martin, McNair, & Hight, 1988) and the completion of standardised measures (Nuetzel & Larson, 2012). Denner and Halprin (1974) contacted clients (n=86) by telephone after termination from a hospital outpatient facility to evaluate their satisfaction with the service, and found that those who had prematurely terminated were less satisfied. Martin et al. (1988) surveyed clients (n=128) who had unilaterally terminated from a University counselling service to find out their reasons for termination, and found that clients lacked time, no longer required the service, or forgot their appointment. The researchers acknowledged that a limitation of the study was that the telephone survey "probably biased respondents in favour of not blaming their counsellors for their premature termination" (p. 235). Moras (1985) reported the same limitation in her follow-up study of premature terminators (n=68) using a questionnaire.

Other quantitative studies have compared data collected from premature terminators to remainers to determine factors associated with PT. For example, clients in a psychotherapy clinic were asked to complete a range of weekly measures assessing themselves and the therapeutic relationship. Seven clients who prematurely terminated were compared to remainers. They found that client openness and the quality of the therapeutic relationship differentiated the two groups (Nuetzel & Larson, 2012). Few differences were found between premature terminators (n=14) and remainers (n=50) in a follow-up study at a mental health facility, and it was concluded that treatment needs to be investigated on an individual basis (Papach-Goodsitt, 1985). This finding was replicated by Fray (2000) in a University setting. Papach-Goodsitt (1985) found that premature terminators felt that their therapists

liked them less, which may reflect something about therapists' attitudes or other factors, such as clients' experiences of being in relationships.

Although quantitative research involving clients has been helpful in determining, for example, client satisfaction measures, reasons for PT, the post-treatment functioning of clients, and comparing clients, it has not provided rich data about how the therapy process unfolds. To understand this process, it is argued that it is necessary to involve clients in research beyond asking them to fill in measures and standardised questionnaires, and to engage in qualitative research.

2.2.2 Qualitative studies

Studies involving clients which include a qualitative component are shown in Table 1. The value of including even a small qualitative component in research is evidenced in Anderson's (2015) online survey (n=278; premature terminators=152). Although this was a predominantly quantitative survey, some open-ended questions were included. It was found that participants' responses to the category of 'unmotivated for therapy' included comments more accurately related to the category of 'dissatisfaction'. The inclusion of the qualitative component allowed the researcher to identify differences in thinking about the pre-determined categories. The limitations of questionnaire-based research were illuminated in Moras' (1985) research, which used both questionnaires and interviews to assess whether clients perceive dropout as treatment failure. No difference in attitude towards therapists was found between premature terminators and remainers based on the questionnaire data, but the interview data suggested otherwise, for example therapists were described as "cold" and "uncaring" (p. 64).

Most research has been carried out in clinics or university settings. Little research has focused on private practice. The first study asking clients their reasons for termination is included because it does capture elements of clients' experiences (Garfield 1963), as do the other early studies (Acosta, 1980; Pekarik, 1983b).

Table 1

Overview of qualitative research about premature termination involving clients

Author	Country	Setting	Method	Definition of premature termination	Size of sample	Type	Key findings / themes
Acosta, 1980 Study: *Self-described reasons for premature termination*	USA	Public psychiatric outpatient clinic	Telephone interview using open-ended questions	Unilateral decision to leave therapy within 6 sessions without notifying therapist	74	3 ethnic groups ➢ US Mexican Americans ➢ Black Americans ➢ Anglo-Americans	➢ Reasons for premature termination ➢ Attitude towards therapy for others ➢ Attitude towards therapy for self ➢ Received help elsewhere
Adler, 2013 Study: *To understand the experience of dissatisfied patients who drop out of psychoanalysis*	USA	Various	Interview	Unilateral termination	6	Psychoanalytical patients (5/6 were therapists who were dissatisfied)	➢ Anger ➢ Criticism of the analyst ➢ Lack of understanding ➢ The authority of the analyst ➢ Self-criticism ➢ The analyses were not entirely bad
Anderson, 2015 Study: *Premature termination of outpatient psychotherapy: Predictions, reasons, and outcomes*	USA	Various	Online survey including open-ended questions	Unilateral termination	157	Various	➢ Predictors of premature termination ➢ Reasons for premature termination ➢ Number of differences between remainers and premature terminators in outcomes

Author	Country	Setting	Method	Definition of premature termination	Size of sample	Type	Key findings / themes
April and Nicholas, 1997 Study: *To investigate reasons for and experience of counselling for premature terminators*	South Africa	University counselling centre	Mailed questionnaire including open and closed questions	Unilateral termination	20	Students	➢ Reasons for premature termination ➢ Experience of counselling ➢ Reasons for improvement during counselling
Bados, Balaguer, and Borghi, 1965 Study: *To discover reasons for premature termination of psychotherapy*	Spain	Behavioural therapy unit of a University	Completed standardised Minnesota Multiphasic Personality Inventory and interview	Stopping before completing 14 sessions	89	Cognitive-behavioural therapy patients	➢ Reasons for PT ➢ No difference in demographic variables between remainers and those of therapist-terminators reported ➢ Premature terminators reported dissatisfaction and lack of information
Saldana, 2007 Study: *To discover investigation of treatment attrition in psychotherapy*	USA	Mental health center	Questionnaire and reason for dropout	Unilateral termination	29	Various	➢ Reasons for PT ➢ Expectations incongruent with therapist
Hepworth and Gladstone, 1984 Study: *To assess satisfaction with psychotherapy*	USA	Community mental health center	Questionnaire by therapist and telephone secretary	Unilateral termination	14	Various	➢ 71% premature terminators reported satisfaction like to present with diagnosis not related to anxiety
Chatfield, 2013 Study: *Investigating client premature termination from psychotherapy*	UK	National health service	Semi-structured interview	Unilateral termination	5	Clients with personality disorder	➢ Pre-therapy context ➢ Institution demands ➢ Reasons for PT ➢ Premature terminators
Cabassa, Torres, and Hansen, 2010 Study: *Understanding premature termination of psychotherapy among Latinos*	USA	Community mental health center	Semi-structured interview	Unilateral termination	8	Latino clients with depression	➢ Cultural dissonance ➢ Beliefs, experiences, expectations
Dalton, 1968; Wachtel and Turner, 2003 Study: *Investigating client premature termination from psychotherapy*	USA	Community mental health center	Semi-structured interview	Unilateral termination by mutual agreement	20	Various (10 anorexia nervosa (all outpatients)	➢ Premature terminators ➢ Reasons for PT ➢ Expectations ➢ Therapist competence ➢ Therapy sessions
Edwards, Hill, Hess, Ladany, and Wahass, 2011 Study: *Psychodynamic therapists' perspectives on premature termination*	USA	Outpatient psychoanalytic psychotherapy center	Questionnaire and client reasons obtained by meeting at last scheduled session or by telephone or mail	Therapist view termination (typically unilateral premature termination)	40	Students and professionals) psychotherapy clients (all female)	➢ Psychoanalytic psychotherapy ➢ Reasons for PT ➢ Goals ➢ Efforts of the therapist ➢ No differences between terminators and remainers ➢ Prior treatment ➢ What did people
Frayn, 2000 Study: *To understand dropout from adult psychotherapy*	Brazil	University psychotherapy training clinic	Baseline interview by therapist Post-treatment interview by researcher	Therapist view	6	Various	➢ Premature terminators ➢ Change process ➢ Dependency ➢ Resulting in the
Nunes, and Eizirik, 2011 Study: *What predicts premature termination of psychotherapy?*	USA	University psychoanalytic psychotherapy center	Questionnaire and interviews	Therapist view	40	Students and professionals) psychotherapy clients (all female)	➢ Psychoanalytic psychotherapy ➢ Reasons for PT ➢ Goals ➢ Efforts of the therapist ➢ No differences between terminators and remainers ➢ Prior treatment ➢ What did people
Dixon, 2011 Study: *To understand dropout from adult psychotherapy*	UK	Not stated psychotherapy training clinic	Post-treatment interview by researcher	Unilateral premature termination)	8	Various	➢ Premature terminators ➢ Change process ➢ Dependency ➢ Resulting in the
Chapman, 1983 Study: *Patients' experience and perspective on premature termination of psychotherapy*	USA	Private clinic	Questionnaire included open-ended question	Therapist view after a minimum of 6 sessions (excluded	61	Psychoanalytic clients	➢ Premature terminators ➢ Change process ➢ Dependency ➢ Resulting in the
Garfield, 1963; Shahdipour, and Wedyer, 2010 Study: *To ascertain reasons for termination of psychotherapy*	Iran	Psychiatric institute outpatients	Questionnaire and interview	Dropped out of therapy prior to	71	Various	➢ Reasons for PT ➢ Premature terminators
Moras, 1985 Study: *Exploration of reasons for termination of psychotherapy*	USA	Community mental health centre	Questionnaire and semi-structured interview	Unilateral termination	68	Various	➢ Reasons for PT ➢ Premature terminators
Study Clients *dropping out of psychotherapy: A qualitative study* *clients' reasons for leaving therapy*	USA	University	Survey including open-ended questions	Unilateral termination	105	Terminating clients	➢ Reasons for PT ➢ Premature terminators ➢ Unprepared clients ➢ Interview data indicated self-premature ➢ Psychotherapy as non-threatening ➢ Psychotherapy as non-judgmental

Table 1 (continued)

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Table 1 (continued)

Author	Country	Setting	Method	Definition of premature termination	Size of sample	Type	Key findings / themes
Orcutt, 2013 Study: *Premature termination from the client's perspective*	USA	Various	Semi-structured interview	Unilateral termination	16	Various Included 2 therapists and 8 trainee therapists or mental health professionals	➢ Expectations of therapy ➢ Experience of therapy and therapist ➢ Explanation for ending ➢ Decision-making process ➢ Reflections on the decision ➢ Future psychotherapy ➢ Impact of decision
Pekarik, 1983b Study: *Asking clients their reasons for dropping out*	USA	Community mental health center	Telephone interview and questions by mail	Therapist view	46	Various	➢ Reasons for termination ➢ 'No need for services' and 'environmental constraints' ➢ Premature terminators reported significant decreases in symptoms
Reynolds, 2001 Study: *Premature termination: the patient's perspective*	USA	University-affiliated urban mental health center	Follow-up interview using standard questions and open-ended questions	Unilateral termination	157	Various	➢ No difference between premature terminators and terminators ➢ Premature terminators reported less benefit

Table 1 (continued)

Author	Country	Setting	Method	Definition of premature termination	Size of sample	Type	Key findings / themes
Scamardo, Bobele, and Biever, 2004 Study: *Using clients' perspectives to understand self-termination*	USA	Psychology training clinic	Semi-structured interview by telephone	Unilateral termination	9	Various	➢ Prediction of therapy length ➢ Termination decisions ➢ Changing expectations of therapy
Wilson and Sperlinger, 2004 Study: *Exploring unilateral discontinuation of therapy*	UK	NHS clinic (4) Private clinic (2)	Semi-structured interview	Unilateral termination	6	Psychoanalytic clients	➢ Avoidance of painful feelings ➢ Conflicting wishes for functional help versus intensive therapy ➢ Detachment from versus involvement with the therapist ➢ Therapy as a threat and a loss of control ➢ Fears of dependence, loss or abandonment

In terms of exploring clients' experiences, a growing corpus of published studies exist (Bein et al., 2000; Eivors et al., 2003; Jung et al., 2013; Khazaie et al., 2016; Knox et al., 2011; Wilson & Sperlinger, 2004), as well as some unpublished theses. A thematic analysis of studies including a qualitative contribution has been carried out and is now discussed. There are a number of limitations, which I will address first.

Much of the research has been carried out in the USA, and this may impact on how clients view therapy from cultural and economic perspectives. There are also differences in the modalities of therapy included in the studies, and a criticism could be that it is difficult to generalise about findings. A counterargument is that the literature identifies the common factors, which are pantheoretical, as facilitating change (Lambert & Barley, 2001). A meta-analysis comparing different treatments and dropout rates carried out by Swift and Greenberg (2014) supports this view. This meta-analysis reviewed 12 disorder categories and only found significant differences in treatments for depression; eating disorders; and posttraumatic stress disorder. More significantly, qualitative research does not seek to generalise but to provide insights which may develop practice. Another limitation is that there are considerable differences regarding the definition of PT used. This is consistent across all dropout research and remains unresolved. A more useful way of defining PT may be to allow clients to self-select as having prematurely terminated therapy, and then to interview them to understand their experiences (Orcutt, 2013).

2.2.2.1 Clients making sense of therapy

The qualitative research into clients' experiences of dropping out of therapy illuminates clients' self-talk. Some clients experienced therapy as a repetition of past failed relationships (Adler, 2013; Chatfield, 2013), or saw PT itself as a sign of immaturity (Adler, 2013). Although it is recognised that the client's interpersonal history may impact on the therapeutic process, the finding that "pre-existing problematic perceptions of interpersonal relationships were reinforced, rather than being addressed in therapy" (Chatfield, 2013, p. 67) raises questions about how co-constructed the process of therapy was for some clients. Adler (2013) conveyed how isolated clients can feel in therapy in:

> "And she said, "Oh, we're in this together." And I thought no, you are wearing your Armani suits, and you have this practice, and you are doing

> fine, and it's your career. But I am spending all this money, and I felt as if I were in an eddy in the water drowning…". (p. 54)

The client's willingness to accept sole responsibility for therapy was illustrated by clients not being clear how to use therapy, for example "I'm sure the therapist was there to help me. I could just never think of anything to say during the sessions" (Jackson, 1969, p. 352). This could lead some clients to leave and try to resolve their problems alone (Borghi, 1965). Of concern are accounts of problematic terminations that left clients feeling traumatised (Knox et al., 2011).

Studies exploring clients' reasons for PT have identified improvement or satisfaction as a reason for client dropout (Acosta, 1980; April & Nicholas, 1997; Granley, 2001). It is recognised that the two terms are not necessarily the same, but both indicate that the client has decided that therapy is no longer needed, and take into account the possibility that the client is able to achieve their goals without the therapist. This was supported by Knox et al.'s (2011) study, which interviewed clients (n=12) about their experience of termination, and found that none of the clients with a problematic termination achieved their goals, and only a few clients with a positive termination achieved their goals. This suggests that clients reconfigure what is 'good enough' in their experience of therapy. Unfortunately, this study did not include any findings if they related to single cases. The follow-up adjustment of premature terminators was assessed by Pekarik (1983a) and mild symptom improvement was reported, although better adjustment was associated with longer duration in therapy.

Several studies have reported dissatisfaction as a reason for PT (April & Nicholas, 1997; Bados et al., 2007; Bein et al., 2000), with 19% of Acosta's (1980) sample "perceiving therapy as of no benefit" (p. 441). The study by Bados et al. (2007) looked at reasons why clients prematurely terminate cognitive-behavioural therapy, and nearly 47% of the clients who provided a reason (n=60) reported low motivation and/or dissatisfaction with either the treatment or therapist. Conflating these two reasons is unhelpful, and could suggest causality. A number of factors associated with dissatisfaction were identified by Khazaie et al. (2016) including distrust and poor skills of therapist, and physical and contractual issues connected to the setting. The experience of dissatisfaction in PT was characterised by anger; criticism of the

therapist; lack of understanding; power struggles between client and therapist; and self-criticism in Adler's (2013) study.

Environmental factors have also been identified as a reason for PT in a number of studies (Acosta, 1980; Bados et al., 2007), although Orcutt (2013) found that environmental factors were not a primary concern. More recently, the availability of 'pseudo-pyschology' was identified as contributing to dropout (Khazaie et al., 2016):

> "My main reason for terminating psychotherapy was my information level about psychology. I searched about psychology on the internet and read psychology books with interest. When I went to psychotherapy, I felt her advice was repetitive, and I knew all of them. She did not give me new information, and could not help me". (p. 27)

2.2.2.2 Clients making sense of the therapist

A negative attitude towards the therapist was the dominant theme to emerge from Acosta's (1980) study, which looked at the reasons why patients (n=74) drawn from ethnic groups prematurely terminated therapy. Unfortunately, no rich data were provided to assess how this attitude may have developed. In contrast, the in-depth studies provide rich data but they are based on small sample sizes. Adler's (2013) study (n=6) provided insight into what clients mean when they report dissatisfaction with their therapists. He referred to therapists who "didn't take any responsibility for participating" (p. 54); "acted like an authority who provided her with insight, rather than helping her develop insight herself" (p. 50); engaged in too much small talk or too much self-disclosure; ignored feedback; and were unwilling to consider that their behaviour might be causing dissatisfaction. The idea that therapy was 'chatting' and unchallenging was identified in Orcutt's (2013) study (n=16). Therapists' non-verbal behaviour was found to impact on clients negatively:

> "I remember one of our last sessions. He was sick, he was not feeling well. I could see that he was sick. He yawned at one point. And I honestly was a bit turned off by that…part of me was frustrated with him that I didn't feel like he was attentive". (Orcutt, 2013, p. 103)

Similarly, Borghi's (1965) study, which compared terminators (n=29) with remainers (n=29), discovered unhelpful therapist behaviours such as "he couldn't remember

what I had told him before!"; "he was strong on telling me how I felt, but I didn't feel that way"; and "he was a continual clock watcher" (p. 32). Silence and a lack of small talk on the way to the therapy room (Chatfield, 2013), and feeling unheard (Dickson, 2015; Knox et al., 2011) were further criticisms of therapists. A sense of being encouraged to 'open up' in therapy prematurely was also considered to be unhelpful by clients who dropped out of therapy (Reynolds, 2001).

2.2.2.3 Clients making sense of the relationship

Hill et al. (1993) caution that "therapists sometimes become inoculated after hearing so much in therapy and forget how painful it is for clients to reveal what they perceive as shameful or embarrassing" (p. 285). Unresolved ruptures were present in problematic terminations (Knox et al., 2011; Orcutt, 2013). The client's perception of a poor therapeutic relationship created dissatisfaction in Adler's (2013) study, and was the main reason for PT in Orcutt's (2013) study where clients reported that increased empathy or communication could have sustained the therapy. These qualitative studies challenge Tryon and Kane's (1993) findings regarding the working alliance. This quantitative study investigated the relationship between working alliance after session three, and type of termination. They found that termination type was *no*t related to clients' (n=103) ratings of the working alliance. Therapists' (n=10) ratings, however, did predict termination status, and they found a weaker working alliance with clients who unilaterally terminated than with clients who terminated mutually. It was speculated that this may be because clients rate the therapeutic relationship as more favourable than the other relationships in their lives, and that therapists rate the alliance on the basis of a range of clients. The qualitative research, however, illuminates that the therapeutic alliance *does* matter to clients, in ways this quantitative study failed to show.

One of the most surprising findings was that clients denied they had dropped out of therapy, and believed that there had been an appointment mix-up or that they had been referred to another service (Acosta, 1980; Borghi, 1965). While it is recognised that errors and misunderstandings can occur, this finding says a lot about the therapeutic relationship. In Orcutt's (2013) study, an appointment mix-up diminished the client:

> "We had had the same appointment at least a year and there was no inclination that we had…There was no hint of us talking about rescheduling. And I showed up and sat in the waiting room. I thought, maybe this is an emergency? Maybe she is sectioning right now? Maybe something is really happening? And I waited the whole fucking hour. Then she came out and said "oh my gosh. I can't believe I did that…That is the worst thing you can do." It really is". (Orcutt, 2013, p. 107)

Not only do clients' and therapists' perspectives diverge about reasons for termination (Hunsley et al., 1999), but also about the nature and duration of therapy (Borghi, 1965; Jung et al., 2013). Scamardo et al. (2004) interviewed clients (n=9) to explore self-termination and found that clients do not discuss their anticipated number of sessions. It was found that "six of the nine participants believed that clients are better judges of how long therapy should last than are therapists" (p. 33). In terms of goals for therapy, Moras (1985) provided a clue to a potential problem:

> Since one of the primary goals of therapy is to increase a person's adaptive interpersonal behaviour (i.e., relating to others in ways that create mutually satisfying interactions and relationships), the fact that a person ends the therapy relationship without informing the therapist of his/her plans is prima facie evidence that one of the main goals of psychotherapy was not achieved. (p. 3)

The above is a therapist's goal and not necessarily a client's goal, and failing to differentiate between what a client could achieve in therapy and what the client wants to achieve can lead to tensions in the therapy. Lack of topic agreement may illustrate the occurrence of this (Adler, 2013; Orcutt, 2013), and the feeling that the therapist's agenda is being foregrounded (Adler, 2013). Having unclear goals and expectations have also been experienced as unhelpful (Jung et al., 2013; Orcutt, 2013). Therapists did not appear to address these basic elements of therapy and let therapy 'drift on'.

Finally, the clients' evaluation of the therapeutic relationship was not considered important in most cases in Jung et al.'s (2013) study, and may indicate that psychoanalytic psychotherapy involves different challenges. Interestingly, Adler's

(2013) findings suggested otherwise, which could indicate that the state of the therapeutic relationship is crucial when *dissatisfaction* is present.

2.2.2.4 Reframing dropout

Some clients are looking for a way to escape from therapy. In Wilson and Sperlinger's (2004) study, four out of six clients discontinued at the point of the therapist's holiday. Moras (1985) found that a reason for failing to discuss termination was based on sufficiency of progress and a wish to avoid a therapist who might "talk him into continuing" (p. 67). While some clients are ambivalent about therapy, others are reluctant to discuss certain issues (Dickson, 2015). The client experience studies indicate a potential pattern in terms of how the decision is made to drop out of therapy. Therapy is seen as moving from being beneficial to irritating and of less importance (Orcutt, 2013), or problematic (Dickson, 2015), adding support to the findings of a study by Roe, Dekel, Harel, and Fennig (2006). This study used quantitative and qualitative methods to explore clients' (n=84) reasons for termination. The qualitative aspect revealed the need to be independent of therapy, and being involved in new relationships, as reasons for termination. Orcutt (2013) offered a model of the decision-making process that clients undertake regarding PT, which involved developing thoughts about terminating, considering these thoughts more fully, deciding to terminate, terminating, and reflecting on the decision. A different view is offered by Wilson and Sperlinger (2004) who interviewed six clients about their unilateral termination, and interviewed their therapists separately. They concluded that it is inappropriate to consider PT as representing the success or failure of therapy, and believe that it is more helpful to take into account clients' attitudes about seeking therapy which they conceptualized as discrimination, exposure (to different modalities), and formative episodes. These ideas provide a different perspective to PT, seeing it as part of a learning curve of clients' socialisation to therapy, which is consistent with clients' reports that they would try therapy again but would be more assertive (Orcutt, 2013). In terms of reflecting on the experience of dropping out of therapy, it seems that qualitative research offers the potential to reframe an experience of therapy. One of the participants in Wilson and Sperlinger's (2004) study was able to reflect, "well I think I'm going to have to give more credit than I thought now looking back on it" (p. 228).

2.3 The therapist as client

The literature about clients' experiences of PT has not distinguished between 'therapist clients' and 'non-therapist clients' (Adler, 2013; Knox et al., 2011; Orcutt, 2013). Other studies exploring clients' experiences in therapy have relied on 'therapist as client' accounts, for example in a recent study of clients' experiences of unhelpful therapy, the participants were therapists (Bowie, McLeod, & McLeod, 2016). Nonetheless, it is useful to consider how/if 'therapist clients' might be different from other clients. This consideration of the therapist as client is contextualised in England (see Appendix 1) in line with the data collection used in this study, and includes counsellors, psychotherapists and psychologists.

2.3.1 Therapists' reasons for attending therapy

Therapists are prolific consumers of therapy (Rizq, 2011). A questionnaire study exploring therapists' use of therapy included 1,107 therapists in the UK, and reported that 83.7% of this sample had undertaken therapy (Orlinsky, Schofield, Schroder, & Kazantzis, 2011). Part of the reason for therapists' use of therapy is attributable to the requirement by some training courses for mandatory therapy. The requirement for personal therapy by therapists is well-established in psychoanalytic trainings (Davies, 2009). In humanistic therapy training, personal therapy may form part of the requirement for personal development (McLeod, 2003). Personal therapy is not a requirement in cognitive behavioural therapy training, although it is recognised that therapists may require therapy for personal issues (Laireiter & Willutzki, 2005).

The debate regarding mandatory therapy for trainee therapists is ongoing. The British Association for Counselling and Psychotherapy (BACP) removed the requirement for 40 hours of personal therapy for accreditation in 2005, and this change allowed training providers to decide how to fulfil the BACP's self-awareness criteria (Maltby, personal communication, October 20, 2016). Interestingly, "more than 50% of courses accredited by the BACP require trainees to undergo personal therapy" (Chaturvedi, 2013). The British Psychological Society (BPS) requires chartered counselling psychologists to complete at least 40 hours of personal therapy (BPS, 2014), whereas the UK Council for Psychotherapy allows training organisations to stipulate requirements (UK Council for Psychotherapy, 2015).

Studies exploring therapists' experiences of mandatory therapy have reported mixed results (Rake & Paley, 2009). Financial and time concerns have been key issues for trainees (Kumari, 2011; Moller, Timms, & Alilovic, 2009). Some therapists feel that therapy should be a mandatory part of training (Rake & Paley, 2009; Rizq & Target, 2008a), although others believe that the requirements could be changed (Kumari, 2011). Not all therapists have experienced mandatory therapy as beneficial, and it has been reported that a need to undergo therapy "spoils it in a way" (Rake & Paley, 2009, p. 288). Mandatory therapy raises questions about possible engagement in therapy: "it was difficult because I wasn't going there with a specific problem" (Kumari, 2011, p. 220).

Aside from reasons connected to professional training, therapists give personal and professional reasons for attending therapy (Daw & Joseph, 2007). In a survey study exploring the use of therapy by clinical psychologists in the NHS (n=321), 54% reported personal growth, 33.9% reported help with historical problems, and 41.9% reported help for a period of crisis as reasons for seeking therapy (Darongkamas, Burton, & Cushway, 1994). A later survey study involving qualified therapists working in the NHS (n=48) reported personal growth (n=26) and personal distress (n=24) as key reasons for seeking therapy, although the survey response rate was low (Daw & Joseph, 2007). The low survey response may reflect the inclusion of participants who had positive experiences of therapy. Interestingly, in Daw and Joseph's (2007) study, therapists could provide multiple reasons for seeking therapy but in cases where one reason was given, the predominant reason was personal distress.

2.3.2 Therapists' experiences of personal therapy

Personal therapy has been reported as helpful from professional and personal perspectives (Daw & Joseph, 2007). It has been found to allow therapists to understand that therapy may not necessarily follow 'textbook formulations' (Macran, Stiles, & Smith, 1999, p. 424); gain a view of how therapists work (Grimmer & Tribe, 2001); gain insight into therapy techniques (Murphy, 2005); develop empathy (Rizq & Target, 2008b); and understand what it feels like to be a client (Ciclitira, Starr, Marzano, Brunswick, & Costa, 2012). It has also been experienced as a helpful source of personal development and self-care (Daw & Joseph, 2007); a way of coping with work-related stress (Darongkamas et al., 1994); a way of resolving

personal difficulties (Kumari, 2011); and a way of improving self-esteem and personal lives (Darongkamas et al., 1994). The research suggests that personal and professional development overlap (Ciclitira et al., 2012; Rake & Paley, 2009).

Studies have also referred to 'therapist clients' experiencing unhelpful aspects of personal therapy (Williams, Coyle, & Lyons, 1999). Negative experiences reported include the therapist having an unhelpful manner (Rake & Paley, 2009); therapist self-disclosure (Kumari, 2001); therapist failure to meet expectations (Rizq & Target, 2010); and therapist lack of attunement (Rizq & Target, 2010).

In summary, 'therapist clients' undergo therapy for a range of reasons. Some reasons are unique to being a therapist, for example training reasons, and there is evidence that therapists critically evaluate their therapists' performance drawing on their insider knowledge of therapy (Rizq & Target, 2010; Von Haenisch, 2011). Therapists also use therapy for professional development reasons. This is in line with 'non-therapist clients' who may use therapy for professional development reasons, for example to improve relationships at work (Carroll, 1996). Like other clients, 'therapist clients' use therapy for personal reasons. The negative experiences reported by 'therapist clients' are comparable to those of 'non-therapist clients' (Dickson, 2015). In conclusion, although there are some differences between 'therapist clients' and other clients, with respect to the need for and experiences of mandatory therapy, the research indicates there is overlap between the reasons for seeking therapy as well as the experiences of therapy between 'therapist clients' and other clients. This lack of differentiation between 'therapist clients' and 'non-therapist clients' is exemplified in Orcutt's (2013) finding that "even those participants who are highly educated in psychotherapy and are therapists themselves struggled to communicate their needs to therapists" (p. 151).

2.4 Causes for concern

2.4.1 Impact on the client

The literature tends to focus on the impact of dropout in terms of poor utilisation of scarce mental health resources, therapists' downtime, therapists' self-esteem (Schaeffer & Kaiser, 2013), and the non-improvement of clients' symptoms (Nuetzel & Larsen, 2012). While it is recognised that dropout itself may be therapeutic (Orcutt, 2013), little attention has been paid to the absence of closure from clients'

perspectives. A sense of failure can exacerbate non-resolved problems (Ogrodniczuk et al., 2005). Some clients may become worse (Knox et al., 2011), and others have reported feeling isolated (Eivors et al., 2003). Clients with unresolved losses appear to be particularly vulnerable if endings are not fully worked through (Knox et al., 2011). Lippman (1983) referred to the regret that some clients experienced about dropping out, and found that this increased over time. On the other hand, Orcutt (2013) found mixed responses. Eleven of her participants said that they would they drop out from therapy again and possibly at an earlier stage, while the other five participants were regretful of their decision and would return.

2.4.2 Loss of data

Clients who drop out of therapy are difficult to contact (Pekarik, 1983b). Client attrition leads to data attrition, and problems evaluating therapy (Bados et al., 2007). Further, the conclusions from therapy research may not be relevant to clients who drop out of therapy (Gibbard & Hanley, 2008). Gilbert et al. (2005) found that post-therapy outcome measures were completed by only 7.7% of clients who dropped out of therapy. The emphasis in the NHS on including users in research necessitates understanding clients' experiences of therapy, and it has been suggested that questionnaires about therapy experiences are more likely to be returned by clients who had a positive experience (Lucock, Leach, Iveson, Lynch, Horsefield, & Hall, 2003).

2.4.3 Therapists' failure to understand why clients prematurely terminate therapy

A number of studies have examined therapists' beliefs about why clients have dropped out of therapy. Pekarik and Finney-Owen (1987) surveyed therapists (n=173) and compared their responses to client and service data. Therapists reported improvement as the primary reason for dropout "but were less prone to acknowledge clients' dislike of therapy or the therapist as a reason" (p. 128). Hunsley et al. (1999) reviewed 194 files to ascertain therapists' reasons for client PT, and interviewed clients (n=87) by telephone. Little agreement was found between the dyads. In cases where therapists reported termination as a result of goal achievement, 78% of clients agreed. Conversely, in cases where clients reported achieving goals as a reason for terminating, only 48% of therapists agreed. The findings indicate that therapists are poor at identifying therapeutic failure and understanding the client's

perspective. These findings were replicated in a later study by Todd, Deane, and Bragdon (2003) but this study used archival data only. It is questionable how willing clients are to be congruent about reasons for termination to their therapists or services at the end of or after therapy. Westmacott, Hunsley, Best, Rumstein-McKean, and Schindler (2010) carried out a study investigating factors related to PT involving clients (n=83) and therapists (n=35). The extent of non-agreement about what happens in therapy was reinforced by the fact that 31 dyads agreed that the client had unilaterally terminated; 52 dyads agreed that termination was mutually agreed; and 24 of the dyads could not even agree about the type of termination.

While it is reported that some clients terminate for reasons out of their awareness (Westmacott & Hunsley, 2010), therapists also have limited awareness of things clients leave unsaid (Regan & Hill, 1992), and they have been criticised for privileging their clinical judgment over frequent assessments of progress with clients (Lambert, Harmon, Slade, Whipple, & Hawkins, 2005). In a study asking therapists (n=11) to consider factors that may have contributed to PT, many therapists said they did not know how to avoid client dropout (Piselli, Halgin, & MacEwan, 2011). Therapists tend to consider client factors to be the reason for dropout when considering their own clients, possibly indicating a self-serving bias (Murdock, Edwards, & Murdock, 2010). A concern about how therapist performance is evaluated (Connell, Grant, & Mullin, 2006); and countertransference (Kächele & Schachter, 2014) may also influence therapists' explanations about PT.

2.5 Conclusion

This chapter has contextualised this study within a theoretical framework including the literature about PT, theories to explain PT, client experience studies, and related practice concerns. Wilson and Sperlinger (2004) concluded,

> when the responses of patients who drop out of therapy are taken at face value, the findings are consistent with those of previous quantitative studies of dropout….however, when the responses are subjected to a *qualitative* and *interpretative* analysis, a more complex picture emerges. (p. 234)

The qualitative studies provide a rich tapestry of clients' experiences of PT. Research to develop further understanding of clients' experiences of PT and the experience of dissatisfaction when this is given as a reason for PT by clients could be

valuable to inform and thus help improve practice, and gain insight into how to respond to clients. This study is a contribution to address these needs. It is suggested that if therapists understand clients' experiences, this may create an opportunity to intervene to avoid unhelpful experiences. The next chapter discusses the methodological considerations and methods used in this research.

Chapter 3: Methodology and methods

This chapter will discuss the methodological considerations and the methods used to answer the research question: *What is the experience of clients who prematurely terminate therapy?* Philosophical influences will be presented in section 3.1, followed by an acknowledgement of my role in the research process in section 3.2. The research design will be justified in section 3.3, and the methodological considerations and method for stage one (section 3.4) and stage two (section 3.5) of the research will be presented. Quality issues will be presented in section 3.6, and ethical considerations will be presented in section 3.7. Section 3.8 presents reflexive comments, and section 3.9 summarises this chapter.

3.1 Philosophical considerations

This methodology is influenced by the constructivist-interpretivist paradigm as defined by Ponterotto (2005). This paradigm seeks to understand the experience of the individual and recognises that experience "occurs within a historical social reality" (Ponterotto, 2005, p. 129). Ontology is the study of the nature of reality. The constructivist-interpretivist paradigm rejects "the existence of a single "objective" reality that can be measured and statistically analysed to reach generalizable conclusions" (Maxwell, 2010, p. 475), and is aligned with relativism. Relativism values multiple realities. This philosophical position is compatible with my research question which seeks to understand the experiences of clients. It is not the intention of this research to derive a 'truth' of the experience of prematurely terminating therapy and to generalise the findings.

Epistemology is concerned with the study of knowledge and considers how we know. It is concerned with the relationship between the researcher and the participants. The constructivist-interpretivist paradigm adopts a transactional and subjectivist epistemology, which recognises that findings of the research are co-constructed (Ponterotto, 2005). This involves a hermeneutical approach. It is recognised that access to participants' experiences is mediated through my interpretative lens, and that any knowledge produced is partial, depends on context, and "tells one *story* among many that could be told about the data" (Braun & Clarke, 2013, p. 20). This philosophical position acknowledges that meaning is created rather than discovered, and is compatible with seeking a purposeful sample, adopting

an idiographic focus, reflecting on the choices and interpretations made throughout the research process, and analysing the data inductively. The inclusion of participants' voices, through the use of quotes in the presentation of the findings, is consistent with the rhetoric of the constructivist-interpretivist paradigm (Ponterotto, 2005). After careful consideration, I have used first person language throughout this thesis and this is also consistent with the constructivist-interpretivist paradigm (Ponterotto, 2005).

3.2 Role of the researcher in the research process

I have endeavoured to be open and respectful to participants' experiences, as well as tentative, in my interpretations. These values also underpin my practice as a Counsellor. Any understandings developed from participants' accounts depend on my engagement and interpretation. This necessitates the adoption of a reflexive approach (McLeod, 2011). In qualitative research, the subjectivity of the researcher is present throughout all stages of the study, and it is considered important to take account of this subjectivity by keeping a research journal (Etherington, 2004). Throughout the research, I have kept a journal where I have recorded my responses to the research, as well as my considerations of the choices and tensions I have faced in conducting the research. Personal reflexivity has involved thinking about how I have shaped the research and how the research has impacted on my practice. Epistemological reflexivity has related to considering the impact of the research choices on the understanding of the phenomenon (Willig, 2013). Opening and closing reflexive statements are presented in sections 1.5 and 7.5 respectively. Reflexive comments on the methods used are included in section 3.8.2. The limited word count for this thesis prevents the inclusion of a reflexive commentary throughout but extracts are provided in Appendix 10.

3.3 Research design

It is difficult to access clients who have dropped out of therapy (Baekeland & Lundwall, 1975). Some US studies have managed to recruit clients who have dropped out of therapy by offering incentives to participants (Nuetzel & Larsen, 2012; Orcutt, 2013). I did not want to do this to avoid the inclusion of participants who may be motivated by financial gain; additionally such resources were unavailable.

Initially, I tried to recruit participants to be interviewed about their experiences of PT via a local counselling service. The request for participants was given to clients at their assessment appointment. Over a nine-month period no participants were recruited. Online recruitment of participants was then explored as it is considered to be a helpful way to access hard-to-reach participants (Terry & Braun, in press). Gaining permission to advertise the research on websites that attract an audience with an interest in psychological topics proved difficult and, after consideration, I decided not to intrude in the safe spaces of user forums.

In order to proceed with the research, it was necessary to develop a pragmatic approach to answer the research question. It was decided to recruit therapists who had an experience of prematurely terminating personal therapy, to talk about this experience of being a client. I hoped that therapists would be willing to participate in a research study to inform practice and to deepen understanding of an under-researched phenomenon. The recruitment of therapists as participants could also minimise potential risks involved in the research. Therapists typically undergo a significant amount of personal development in training, which could support them in the research process if difficult feelings arose (Bowie et al., 2016). Notwithstanding the use of therapists as participants, this is a study about clients' experiences of prematurely terminating therapy. Therefore, it was not an inclusion requirement that participants referred to experiences of therapy while they were therapists or training to be therapists, and the focus of this study was not on examining the experiences of therapists in therapy. It is argued that therapists engage in personal therapy too and are able to discuss this experience from the perspective of being a client. Rhodes et al. (1994) adopted a similar approach. It was recognised that there are drawbacks of using therapists as participants, for example therapists have a particular understanding of process (see section 7.1.1), but ethical considerations were prioritised given the sensitive nature of the research

The research design comprised two stages. Stage one involved creating an online self-administered qualitative survey[4] to gain an understanding of clients' experiences of PT, and to recruit participants for stage two of the study. This addressed the first aim of the study: to gain an overview of the experience of clients who prematurely

4Terry and Braun (in press) differentiate between the terms 'survey' and 'questionnaire'. Surveys do not require questions to be validated or tested for variability. They suggest that qualitative questionnaire is an unsuitable term.

terminate therapy. Stage two involved carrying out semi-structured interviews. This addressed the second aim of the study: to understand the experience of dissatisfaction when this is given as a reason for PT. Both stages of the research sought to address the third aim of the study: to inform and thus help improve practice. The results of the survey were not used to inform the interviews, although it is recognised that my fore-understandings had changed simply by reading the survey responses. The rationale for this was to stay close to the participants' experiences in stage two.

The methodological considerations and method for each stage are now discussed.

3.4 Stage one: qualitative survey

3.4.1 Methodological considerations

In order to understand clients' experiences of PT generally, which could inform my private practice as a Counsellor working with a range of clients and presenting problems, a qualitative survey was developed. A qualitative survey is a method of collecting textual data from a purposeful sample in response to fixed open-ended questions, which is then analysed qualitatively (Terry & Braun, in press). No existing surveys were found which could be used for this purpose.

Surveys are considered useful for collecting information about sensitive topics (Robson 2011), and qualitative surveys are considered suitable for understanding experiences (Terry & Braun, in press). This method allowed participants to decide how and when they responded (Terry & Braun, in press), and enabled me to obtain "a 'wide-angle picture'" of the research question (Toerien & Wilkinson, 2004, p. 70). The decision was taken to distribute the survey online, to enable participants to respond anonymously (Braun & Clarke, 2013), and it is suggested that this is attractive to 'hard-to-reach' populations (Terry & Braun, in press). Limited resources meant that it was not possible to advertise the research in national newspapers or on the radio.

'SurveyMonkey'[5] was used to create a web-based survey. The rationale for this was that it is well established (Robson, 2011), and the 'SurveyMonkey' privacy policy (SurveyMonkey, 2014) confirms that the data are owned by the researcher and will be stored securely. Participants did not have to answer every question and multiple

5 'SurveyMonkey' is a cloud-based company which enables customers to develop online surveys.

transmissions were not possible. To ensure that participants' responses were anonymous, Internet Protocol (IP) addresses were not collected, and data collected were encrypted. These considerations complied with ethics guidelines for Internet-mediated research (BPS, 2013). 'SurveyMonkey' offered the functionality to manage these ethical concerns.

Braun and Clarke (2013) suggest collecting between 50 and 100 responses for a qualitative survey for a medium-sized project. Fifty responses were collected to reflect the limitation of being a sole researcher. The choice of method to analyse the data was based on the data collected. The qualitative data collected from the surveys were 'thin', and this created a challenge in terms of engagement. This meant that methods such as interpretative phenomenological analysis (IPA), which rely on thick data, were inappropriate to analyse the data (Terry & Braun, in press). Thematic analysis was chosen as it is a flexible and widely used analytic method that searches for patterns across the dataset, and is epistemologically flexible (O'Reilly & Kiyimba, 2015).

3.4.2 Method

3.4.2.1 Participant information and consent

The first page of the survey was the participant information sheet (PIS) (see Appendix 2). The information provided on page one of the survey followed guidelines in the literature concerning disclosure of information, for example nature of the study, and how the data would be used (Mann & Stewart, 2000).

The inclusion criteria for the survey were as follows:

1. Participants were over 18 years old.
2. Participants were counsellors or psychotherapists.
3. Participants had an experience of prematurely terminating adult individual counselling or psychotherapy as a client.
4. Participants were not suicidal.
5. Participants lived in England.
6. Participants were fluent in English.

Informed consent was sought by asking participants to select three radio buttons to indicate agreement to the consent statements (see Appendix 3). It was not possible to continue with the survey unless consent was given (BPS, 2013). The rationale for specifying that clients should live in England was to set a geographical boundary for

the research because stage two of the study involved interviewing participants. This reflected the limited resources available for the study. It was also possible that legal differences might apply to research carried out in other countries (Hanley, 2011), and it was decided that it would be beyond the scope of this project to address these.

3.4.2.2 Survey questions

The questions asked were used to situate the sample and to address the research question. The final question asked participants to provide an email address if they wished to participate in an interview if dissatisfaction was the reason for PT.

3.4.2.2.1 Situating the sample

The following questions were asked to provide contextual information about the participants:

1. *Gender*
2. *Age*
3. *What type of therapy did you have?*
4. *What was the therapy setting?*
5. *How long ago did you prematurely terminate therapy?*
6. *Did you seek further therapy after prematurely terminating therapy?*
7. *How many experiences of therapy have you had?*
8. *How many times have you prematurely terminated therapy?*
9. *Did you consider returning to the therapist you prematurely terminated therapy with?*

In order to minimise 'participant fatigue', drop down boxes were offered for responses, along with an 'other' box if appropriate. The questions were placed in a logical order becoming increasingly specific (Kvale & Brinkman, 2009). Participants were not asked about their reasons for seeking therapy to avoid potential harm to participants by asking them to reflect on why they had sought therapy (Bond, 2004). Participants were asked to refer to their last experience of PT if they had more than one experience.

3.4.2.2.2 Questions to address the research question

Open text boxes were provided to answer the following questions:

1. *At what point did you decide to prematurely terminate therapy?*
2. *Do you recall what influenced your decision to prematurely terminate therapy?*
3. *How did you communicate your decision to prematurely terminate?*

4. *How did your therapist respond to you prematurely terminating therapy?*
5. *What response, if any, would have been helpful from your therapist?*
6. *Do you regret prematurely terminating therapy, and if so why?*

The response boxes were not restricted to allow participants to express themselves as fully as possible.

3.4.2.3 Piloting the survey

The survey was piloted with two people who had dropped out of therapy. This was based on the experience of finding it difficult to recruit participants in the first place. It was decided that ten minutes was a reasonable amount of time for participants to complete the survey. The feedback from the pilot study indicated that it was possible to complete the survey within this time but that it would be helpful to have an idea of the percentage of survey completed. A status bar was added to encourage participants to finish the survey.

3.4.2.4 Distributing the survey

'SurveyMonkey' offers an 'online collector' facility. This creates a link to surveys which can be used in advertisements, websites, or emails. The link to the survey was advertised in online groups (see Appendix 4), for example Counsellors and Psychotherapists UK on 'LinkedIn'[6], and emailed to therapists who had expressed an interest in the research. Fifty responses to the survey were collected within six days, including 21 potential interviewees who were emailed to advise that I would be in touch in due course. The sample was purposeful. It is not possible to determine who decided not to participate in the survey, or whether the sample was representative of the population of therapists who have prematurely terminated therapy.

3.4.2.5 Analysis of the survey data

The data to situate the sample were analysed to determine percentages, and bar charts were created for presentation purposes. The qualitative data were copied into an 'Excel'[7] spreadsheet, and thematic analysis was used to analyse the data for reasons discussed in section 3.4.1. This process was very time-consuming largely because of difficulties in finding a way to handle the data. Initially, I analysed the data manually but this was messy, and so I decided to add extra columns to the

6 'LinkedIn' is an online networking site for professionals.
7 'Excel' is a spreadsheet programme.

'Excel' spreadsheet to develop the themes. A reflexive journal was kept throughout this process. Thematic analysis was carried out in an inductive way. This means that the themes were not determined by pre-existing theories or conceptual frameworks but were generated from the data in a 'bottom up' way. I tried to understand the meaning of participants' responses and employed an 'empathic' approach (see Smith, Flowers, & Larkin, 2009). The analysis was informed by my philosophical considerations. Hjeltnes, Binder, Moltu, and Dundas (2015) used thematic analysis in a similar way.

The guidelines offered by Braun and Clarke (2006) were used to analyse the data as follows:

1. Repeated readings of the data were carried out to gain familiarity and an overview of the dataset. During this stage, initial ideas were noted.

2. I looked across the entire data set and coded the data. The codes represented "a feature of the data" (Braun & Clarke, 2006, p. 88). This process was carried out three times. The codes were then collated. Figure 3 below gives an example of coding:

Figure 3: Data extract from Participant 30

Data extract	**Coded for**
"I felt patronised and not made to feel comfortable. Then I turned up for an appointment that the therapist had not written in his diary. I also felt that they had a set agenda and gave the work a focus I had not gone for. I felt missed and actually quite frustrated"	1. Expectations not met 2. Therapist is careless 3. Therapist agenda 4. Client is diminished

(Participant 30, data extract 53).	

3. Themes were created from stage two to reflect a patterned meaning of the dataset. This was a recursive process. The themes were reviewed in supervision, and the process of creating the themes and the audit trail were discussed in supervision. The result of the analysis was 92 codes, which were then grouped into 20 themes.

4. The themes were reviewed and three overarching themes were created with eight sub-themes to create a coherent understanding of the data. The analysis reflected that "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). The findings of stage one of the research are presented in Chapter 4.

3.5 Stage two: interviews

3.5.1 Methodological considerations

The interviewees were selected from the survey respondents who agreed to be interviewed and provided an email address (see sections 3.4.2.2 and 3.5.2.1). The aim of the face-to-face interviews was to gain an in-depth understanding of the experience of dissatisfaction. The reason for this was that dissatisfaction has been reported as a significant reason for PT by clients (Swift & Greenberg, 2015), and is an under-researched topic. Other approaches to exploring this question were considered. Questionnaires were considered unsuitable because insufficient research exists to determine possible categories, and I did not want to 'impose' a conceptual framework about dissatisfaction. An interview would enable me to probe participants' responses. Online interviews using 'Skype'[8] were considered but it was decided not to pursue this method given my past experiences with the line dropping when using 'Skype'. I did not want to jeopardise the ongoing involvement of hard-

8 'Skype' is an Internet-based service, which allows users to make video and audio calls.

to-reach participants, which is possible through failures in technology (Hanley, 2011).

Several methods were considered to analyse the interviews. Grounded theory adopts an inductive approach to theory development and explanation (Smith et al., 2009). This method was considered unsuitable to answer the research question because I was not seeking to generalise the findings or establish a theory of PT from therapy, and was committed to understanding individual experiences. Discourse analysis (Willig, 2013) explores how language is used to construct social reality rather than understanding how people experience phenomena, and this method would not answer my research question.

IPA was chosen as the "perspective from which to approach the task of qualitative data analysis" (Larkin, Watts, & Clifton, 2006, p. 104). The theoretical underpinnings of IPA are informed by phenomenology, hermeneutics, and idiography[9], and these underpinnings are compatible with the philosophical considerations discussed in section 3.1. The analysis was informed by Heidegger's phenomenology as discussed by Larkin et al. (2006), which acknowledges "the person as always and indelibly a 'person-in-context'" (p. 106). IPA employs a 'double hermeneutic' whereby "the researcher is making sense of the participant, who is making sense of x" (Smith et al., 2009, p. 35). In using IPA, I relied on the participants' accounts, which were viewed through my own lens, and recognised that "without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen" (Smith et al., 2009, p. 37). There are two aims in applying IPA and these are compatible with answering my research question: to endeavour to understand and describe participants' experiences, and to present an interpretative analysis. Larkin et al. (2006) suggested,

> this interpretative analysis affords the researcher an opportunity to deal with the data in a more speculative fashion: to think about 'what it means' for the participants to have made these claims, and to have expressed these feelings and concerns in this particular situation. (p. 104)

The limitations of using IPA are considered in section 7.1.2.

9A discussion of the theoretical underpinnings of IPA is beyond the scope and word count of this study. Please see Smith et al. (2009) for a discussion.

3.5.2 Method

3.5.2.1 Recruitment

I decided to interview six participants based on the number of participants considered appropriate for a doctoral study using IPA as an analytic method (Smith et al., 2009). Two potential interviewees did not talk about dissatisfaction in their survey responses and were excluded. This was necessary because IPA requires a homogeneous sample, which may allow theoretical transferability, to answer the research question. A homogeneous sample is also important in IPA to illuminate convergence and divergence in the accounts. The six interviewees were selected using 'Research Randomizer.'[10] This is a programme which is recommended in good practice for research (Kelley, Clark, Brown, & Sitzia, 2003). An email was sent to six randomly selected participants (see Appendix 5). The PIS (see Appendix 6) and consent form (see Appendix 7) were attached. A period of two weeks was left between sending the emails and carrying out the interviews, to allow potential interviewees to consider their involvement. During the process of arranging the interviews, it emerged that one person lived in Ireland. This did not meet with the inclusion criteria for the study, so they were advised and their data were removed from the survey analysis. An additional interviewee was selected using 'Research Randomizer', and emailed.

The process of arranging the interviews was complicated. Three participants responded quickly and interviews were arranged. I sent my BACP register number and membership number to participants to allow them to confirm my identity. After waiting for two weeks, I randomly selected a further six participants to invite to interview, based on the 50% response rate, and amended the PIS to recognise that interviews would take place on a first come basis. The six interviews were arranged by email at a location and time to suit participants. Three participants were interviewed in their homes; two participants in their work place; and one participant in a local civic office. The geographical spread of participants meant that interviews were carried out over two weeks. In line with the University of Chester's lone worker policy, a trusted person was informed of the location and time of interviews. The details of six local therapists were provided to each participant, in case they wished to access further support following the interview. It was decided that

10'Research Randomizer' is a free resource for researchers and can be accessed at www.randomizer.org.

participants would have the opportunity to amend their transcript. It was also decided that consent would be sought on an ongoing process (see West, 2002).

The topic guide for the semi-structured interviews was based on the questions identified in the 'what will happen to me if I take part?' section of the PIS (see Appendix 6) and also included the following prompts:

- *Could you give me a specific example of that?*
- *Could you say more about that?*

The topic guide was informed by my knowledge of IPA, the gap which had emerged in the literature review, and practice experience. The purpose of the interviews was to understand participants' experiences, and to be open to what they wished to discuss.

3.5.2.2 The interview process

A pilot interview was carried out, which helped to create a checklist of things to remember to do/say in the research interviews, for example telling participants that I may glance at the recorder from time to time to make sure that it was still recording. This pilot interview helped me to think about how to stay close to the participant's experience, for example, I realised that sometimes it was helpful to note down points I wished to probe further as a reminder, rather than to interrupt the flow of the interview. It also helped me to adjust to adopting a researcher role rather than my usual therapist role.

At the start of each interview, I went through the PIS and consent form, and asked participants if they had any questions or concerns. Participants were invited to sign the consent form, and asked to select a pseudonym. It was explained that the interviews would be audio recorded, transcribed, and that participants would have the opportunity to amend their transcript. The process of ongoing informed consent was explained and the ongoing consent form was given to participants (see Appendix 8). Participants were given two self-addressed envelopes to return transcripts and consent forms. In addition, details of six local therapists were given to participants, as well as the sources of support information sheet (see Appendix 9). It was explained that the interview would not explore why participants had sought therapy. This was consistent with the ethical approach adopted in stage one (see section

3.4.2.2.1). I also explained that I was adopting a 'researcher' role to acknowledge the boundary between counselling and researching and the research agenda. I explained that participants could stop the process at any time. Finally, I explained that I might make some brief notes during the interview.

I attempted to get as close to participants' experience as possible by engaging in active listening and probing responses where appropriate. I was sensitive to participants' non-verbal behaviour and vocal tone as well as silences to try and evaluate whether the process was having a negative impact on participants. As far as possible, I attempted to "implement IPA's inductive epistemology to the fullest extent" (Smith et al., 2009, p. 70), by using the interview topic guide flexibly. The extent to which bracketing can be fully achieved is questioned by hermeneutic phenomenological philosophers (Heidegger, 1953/2010). While researchers working in a hermeneutical phenomenological tradition may *attempt* to bracket prior understandings, the extent to which this is possible is restricted because pre-conceptions may only come into awareness *when* encountering new stimuli. This means that "reflective practices, and a cyclical approach to bracketing, are required" (Smith et al., 2009, p. 35). Following Smith et al. (2009), I engaged in reflexivity and bracketing in a continuous and cyclical manner during the interviews. This involved moving through a hermeneutic circle:

> I start where I am at one point on the circle, caught up in my concerns, influenced by my preconceptions, shaped by my experience and expertise. In moving from this position, I attempt to either bracket, or at least acknowledge my preconceptions, before I go round to an encounter with a research participant at the other side of the circle….However, I am also irretrievably changed because of the encounter with the new, my participant and his/her account (Smith et al., 2009, p. 35).

The awareness of my situatedness necessitated an ongoing reflexive approach in the interviews. I was conscious at times of feeling surprised by participants' accounts which alerted me to the fact that I had fore-structures, and I did my best to put these thoughts to one side. At other times I was aware that my personal experiences were very different, and again I attempted to bracket these off to avoid imposing my experiences on participants' accounts (see Appendix 10, examples 3 and 4).

At the end of the interviews, I carried out a debriefing, checked how participants were feeling, reminded them about the sources of further support, and thanked them for their involvement. Participants were positive about their involvement in the research and the importance of the topic. Section 3.8.2 includes some reflexive comments about the interviews.

After each interview, I made some notes about the process and my impressions. The interviews were transcribed immediately to maximise the potential for recall. Transcripts were anonymised, for example names of places, therapists and unusual job titles were changed. Each interview was transcribed and reviewed before the next interview was carried out. In line with IPA's requirement for a semantic record of the interview (Smith et al., 2009), transcripts recorded all speech turns. Pauses, laughter, and explanatory information were noted in brackets, and three dots were used to indicate omitted information.

The use of member checks is not generally associated with IPA given its interpretative nature (Larkin & Thompson, 2012). However, some IPA researchers have used member checks. Ballinger (2012) used member checks in her study as "rejecting a member check entirely felt problematic given the public nature of the role" (p. 141), and Rizq and Target (2008) also used member checks to provide validity for the transcription and preliminary analysis. It could be argued that the practice of member checking is sensible and desirable; it can be seen as empowering participants (Holloway & Wheeler, 2003) and allowing them to continue to co-create research; it can be viewed as a way of minimising the possibility of misunderstandings occurring (Goldblatt, Karnieli-Miller, & Neumann, 2011); and it can be seen as a means of providing validity (Willig, 2013) or establishing quality (Braun & Clarke, 2013). Alternatively it could be argued that this practice is consistent with a realist lens which fails to recognise the interpretative voice of the researcher (Braun & Clarke, 2013). There are ethical considerations involved in carrying out member checks, and it carries some risks. It is possible that participants may not wish to contribute to the research process any further, even if they have agreed to do so in the consent process. Further, being exposed to the research material may create distress as research stories are relived (Goldblatt et al., 2011). This potential distress would take place outside the containing and supportive environment of the research interview. In addition, the participants' thinking may

have moved on since their participation in the research, and any data subsequently received may not reflect their changed perspectives (Corden & Sainsbury, 2006).

I made the decision that I would return the transcripts to participants to allow them to make any changes they wished, to ensure the data had been anonymised to their preferences, and gain clarity if I had difficulty understanding participants' words. This decision was based on reasoning that "the adequate protection of personally-sensitive information about identifiable individuals is a major ethical concern for anyone conducting research about counselling and psychotherapy" (Bond, 2004, p. 7). The discussion about the rationale for the member check of the transcription formed part of the consent process at the start of the interviews as well as part of the ongoing consent process. I decided that I would not use member checks for the analysis as this would involve my interpretation and I recognised that many interpretations of the same data could be possible (Braun & Clarke, 2013). It was hoped that any risks from carrying out a member check of the transcript would be mitigated by the fact that the participants were also therapists (see section 3.3), and that the participants could choose whether to read the transcripts and engage in the ongoing consent process (see Appendix 10, example 6 for reflection on participants' feedback).

Participants were also asked to sign and return the ongoing consent forms if they agreed that their contributions could continue to be used in the research. All consent forms were promptly returned by participants. At this stage, a thank you email was sent to potential interviewees who had not been selected for interview. As outlined in the consent form, two weeks before starting the analysis of the data, an email was sent to participants reminding them of the endpoint for withdrawal. No participants withdrew from the study.

3.5.2.3 Analysis of interviews

The process of transcription was the first stage of analysis, and allowed me to become familiar with the data. The systematic process of analysis was informed by the guidelines offered by Smith et al. (2009). I was also informed by the messiness of stage one of the research, and created an 'Excel' spreadsheet. The transcripts were copied into column one and broken down into data numbers to facilitate cross-referencing. Two further columns were added, one to record the line-by-line analysis

of the text, and the other to record the emergent themes. Smith et al. (2009) suggest starting the analytic process with the 'richest' transcript. I decided to work on the transcripts in a chronological order to avoid making an interpretation of what was 'rich' before the detailed analytic work had taken place. The process of analysis for each interview is now described.

Each transcript was analysed individually in a detailed way after several readings, to reflect descriptive, linguistic and conceptual aspects of the data. The analysis was informed by the hermeneutics of empathy (Smith, 2008). I focussed on the text rather than on pre-existing theory, and on my interpretation of making sense of the participant making sense of their experience. The analysis reflected a Heideggerian phenomenology which sees "interpretation as inevitable, a basic structure of our *being-in-the-world*" (Finlay, 2008, p. 8). This was carried out for every line of the transcript, and was informed by the IPA literature (Smith & Osborn, 2007). Figure 4 presents an example of exploratory comments.

Transcript extract	Exploratory comments
"I *suppose actually you know, she did at times embody the core conditions. You know she was a real, she was very much a warm and caring person so I suppose I definitely got the sense of empathy at times but then it, it all became muddied with these quite strange things that went on*" (Emma).	Therapy was confusing. Emma is having an inconsistent experience. *"Muddied"* suggests contamination? <u>What does it mean for Emma to evaluate her experienced therapist in this way? That she is conflicted? That her therapist is not professional?</u>

Figure 4: Transcript extract number 1157 from Emma's interview

Key to exploratory comments: descriptive comments are in normal text; linguistic comments are in italic type, and conceptual comments are underlined.

After completing the exploratory comments, I developed emergent themes to reflect an understanding of the data. This was a recursive process, and required an analytic shift to working with the exploratory comments rather than the transcript. Appendix 11 provides an example of analysis using an extract from Caroline's interview. I kept a reflexive diary to record the analytic decisions made. I then created a structure of themes by looking for connections across the emergent themes to represent each participant's account, and this involved referring to the whole and parts of the text. The themes were reviewed to check that they were grounded in the participant's account, and were discussed in supervision. For each participant, themes were then arranged into superordinate themes that captured the experience of dissatisfaction for that particular participant, and a table of superordinate themes and subordinate themes with quotations to support the analysis was compiled (Smith & Osborn, 2007).

I engaged in a process of bracketing during the analysis of the individual transcripts. In order to minimise being influenced by previous interviews as far as this was possible, a period of one week was left in between analysing each transcript, and each transcript was read all the way through in the first instance to orientate to the participant's unique experience. After the analysis of each transcript was completed, the 'Excel' spreadsheet and the structure of themes were filed and not referred to while analysing the subsequent transcripts to avoid 'searching' for what had already been found. As I analysed each transcript, I continually reflected on whether the emergent themes were being created inductively with respect to *this* transcript (see Appendix 10, examples 7, 8 and 9 for examples of how I used bracketing during the process of analysis).

The final stage of analysis was a cross-case analysis, which involved looking at all themes across all participants to develop a master table of themes. I created a document which listed all 239 themes across the six transcripts and worked through the list renaming themes that had been worded slightly differently, and combining and renaming similar themes. I returned to the transcripts to make sure that the new themes were still grounded in the data. For one-off themes, I checked the transcript and some of these were re-coded. I looked across the transcripts to check whether themes had been missed in other accounts. Themes were discarded if they were not significant and if they did not answer the research question. I organised the data into

superordinate and subordinate themes in order to answer the research question, and reflect the convergence and divergence in participants' experiences. This process involved combining themes. This process also involved subsumption[11], for example, 'feeling confused' became a superordinate theme for all cases. The final analysis reflected the temporal nature of the experience of dissatisfaction. The superordinate themes applied to all participants, but the subordinate themes did not. Appendix 12 provides an example of how a superordinate theme was created.

3.5.2.4 Writing the analysis

The process of writing the analysis resulted in a further refinement of the analysis. I distinguished between the description of participants' accounts, through the use of verbatim extracts, and the interpretations made which acknowledged "the centrality of researcher subjectivity in this kind of work" (Brocki & Wearden, 2006, p. 97). This enables the reader to assess the extent to which they agree with the interpretations. Smith (2011) suggests that a hallmark of quality in IPA studies is that they present shared themes as well as *"pointing to the particular way in which these themes play out for individuals"* (p. 10). I have attempted to develop an analysis of the data which pays respect to the theoretical roots of IPA: phenomenology, hermeneutics, and idiography. The findings of stage two of the research are presented in Chapter 5, and present a "clear and full narrative account" (Smith et al., 2009, p. 110).

3.6 Quality issues

Little agreement exists regarding how to assess qualitative research. Yardley's (2008) core principles are suitable for evaluating the quality of this study because they take into account important issues such as how context has shaped the study, the internal consistency of the study, and relevance to practice. The principles are identified as:

- sensitivity to context;
- commitment and rigour;
- transparency and coherence; and
- impact and importance.

The application of these principles is now discussed.

11Subsumption "operates where an emergent theme itself acquires a superordinate status as it helps bring together a series of related themes" (Smith et al., 2009, p. 97).

3.6.1 Sensitivity to context

I have demonstrated an awareness of the literature about PT and how this study is situated in that literature. Methods have been chosen which enabled me to answer the research question, and I have acknowledged the impact of wider cultural influences, for example the difficulties in recruiting clients and the challenges of Internet-mediated research. I have included details about participants, about how and where the data were collected, and how the data were analysed. For the surveys, participants were able to answer in an open-ended and flexible way, which enabled contextual information to be included in the responses. For the interviews, I used the interview guide flexibly, and participants were interviewed in a location of their choosing to maximise the potential for their comfort. I attempted to be sensitive to the impact of the research on participants, for example by paying attention to non-verbal behaviour in the interviews and by engaging in an ongoing consent process. Finally, I have endeavoured to be sensitive and respectful in the analysis and writing up.

3.6.2 Commitment and rigour

I have engaged in a detailed study of premature PT through wide reading of the literature. The recruitment of participants has been described and justified. I explored different methodologies and attended a range of training events and conferences.

3.6.3 Transparency and coherence

The detailed stages of the study have been presented. In the survey findings, participants' words have been used. In the interview findings, I have differentiated participants' words by using rich data, from my interpretations, and have followed the guidance offered by pioneers in IPA (Smith et al., 2009). The interpretations are grounded in the data. The analytic process is supported by an audit trail linking back to the raw data. Further, I have been reflexive throughout the research process and kept a reflexive journal.

I have carried out the research in a manner consistent with the spirit of the philosophical considerations presented in section 3.1. I did not use member checks for the findings because it is not considered possible to "expect either expert researchers or respondents to arrive at the same themes and categories as the

researcher" (Rolfe, 2006, p. 305) in qualitative research. I did, however, follow the guidelines with respect to an independent audit to show "how systematically and transparently this particular account has been produced" (Smith et al., 2009, p. 183). I discussed and made visible the analytic process and audit trail in research supervision.

3.6.4 Impact and importance

This refers to whether the research is useful. The reader can ask questions about whether the study has illuminated their understanding of the phenomenon or caused them to reflect. The study has impacted on me and my practice in the following ways:

- I have developed a unique way of answering the research question, which overcame the difficulties in recruiting participants.
- The findings of the research have caused me to reflect on and make changes in my practice.
- I have an understanding of what dissatisfaction means for clients who prematurely terminate therapy, and this informs interventions made in practice.
- I plan to disseminate the findings of this research to inform therapists and clients about PT.

3.7 Ethical considerations

Ethical approval was granted by the Faculty of Health and Social Care Research Ethics Sub-Committee at the University of Chester. This research has been carried out in accordance with:

- the University of Chester's Research Governance Handbook (University of Chester, 2014);
- ethical guidelines for researching counselling and psychotherapy (Bond, 2004); and
- the Ethics Guidelines for Internet-mediated Research (BPS, 2013).

Beyond any ethical guidelines or handbooks, is a personal perspective I bring to this research. Over the years I have been involved in many research projects as a participant, and have had some poor experiences. These have included feeling 'disciplined' to answer a researcher's question in a particular way to satisfy a

particular agenda, experiencing the process as a "hit and run" (West, 2002, p. 264), and being intruded upon beyond what had been agreed in the consent process. These experiences shape my researcher stance.

The following procedures have been followed:

Ethical considerations for the researcher

- Being reflexive throughout the process.
- Adhering to the University of Chester's lone worker policy.
- Discussing ethical concerns and my wellbeing in research supervision.

Ethical considerations for the participant

- Providing information to interviewees to check my identity.
- Meeting at a time and location suited to interviewees.
- Explaining the consent process clearly.
- Carrying out a debriefing at the end of the interviews (Kvale & Brinkmann, 2009).
- Making the endpoint for withdrawal from the research clear.
- Maintaining participants' confidentiality, and storing information securely.

3.8 Researcher reflexivity

3.8.1 Reflecting on my 'insider' position

Researchers are considered to occupy an 'insider' position "when we share some identity with our participants" (Braun & Clarke, 2013, p. 10). This position is not fixed and, informed by Le Gallais' (2008) work, Table 2 considers my positions on an insider/outsider continuum (also see section 1.5). Understanding my 'insiderness' has been facilitated by using a reflective journal, discussing my research in clinical and research supervision, using my 'internal' supervisor, and trying to be reflexively aware throughout the entire research process. Inevitably, my fore-structures have changed and, like other 'insider' researchers, "I have taken these shifting meanings back with me into the on-going research process" (Ballinger, 2012, p. 91).

Table 2

My insider/outsider researcher continuum

Positions on the continuum	**Potential benefits and pitfalls**
Constructivist researcher involved in the co-creation of the research findings.	Intersubjective meaning-making process. The extent to which I can ever

	understand another is limited because I am not that person. Fore-understandings may obscure seeing the 'new'.
Shared experience of PT.	May facilitate empathy. May lead to researcher bias.
Therapist who has experience of my own clients' prematurely terminating therapy (my perspective).	May divert focus from the phenomenological inquiry – need to avoid making assumptions.
Therapist researching with other therapists.	Researcher able to draw on therapist skills to facilitate the research. Share a common vocabulary. Danger of creating a sense of 'being the same' – "overrapport" (Hong & Duff, 2002, p. 194). Danger of slipping into 'therapy' rather than 'research'. Danger of being 'invited' into interviews as a therapist.
Researcher as a therapist seeking to improve practice engaged in a cyclical process of sense-making.	Meeting the aim of the study. Creating new knowledge. Researcher's voice becoming 'too loud'. Researcher reaching premature conclusions.
Knowledge of PT literature.	Able to identify a gap in the literature to inform study and argue for the value of the research. May obscure seeing the 'new'.
Knowledge of the process of therapy.	Provides insights to interpret the research. All knowledge is practical, conceptual and situational – possible to create bias.
Knowledge of the research process.	Potential to adopt a 'superior' position.
Professional Doctorate student.	Researcher also has an objective to write a thesis. Possible for participants to experience the process as an 'hit and run' (West, 2002). Who does the research 'belong' to? Participants may 'defer' to researcher.

Adapted from Le Gallais (2008, p. 151).

Appendix 10 provides some insights into how I negotiated moving between these positions (also see section 3.8.2). At points in the interviews I made conscious decisions to foreground my therapist identity. While I sometimes felt the 'pull' of an invitation from participants to discuss the experience as a 'fellow therapist', I was mindful of focussing on participants' experiences and of not trying to foreground my voice.

3.8.2 Reflexive comments about methods

The online survey was successful in terms of recruiting participants but I was aware that it excluded those not online. Increasingly this limitation bothered me, particularly given that my research involves those who may have felt disappointed by therapy, and the literature suggests that premature terminators often have a low socio-economic status, unlike the online population (Gosling & Mason, 2015). Was I discriminating against the very population I wished to include by denying access to my research by particular groups? These are no easy answers to this dilemma. It is unclear how much of my failure to recruit 'non-therapist clients' in the first place was because I am not 'pushy' enough. Undoubtedly the process of undertaking this Professional Doctorate has changed me, and I would be more confident in future research projects in terms of following up requests to counselling services to advertise my research. I remain fascinated with my research question, and intend to extend this research by finding a way to include those who may have been denied access to this project.

In terms of analysis of the survey data, it was difficult for me to see beyond the answers to questions, to develop the themes to answer my research question, and to come up with a system to facilitate this process. Part of this struggle was that in previous research I used narrative methods, which allow participants' stories to remain comparatively 'intact'. Like Ballinger (2012), I struggled with the 'butchery' of participants' texts. This was more pronounced in the analysis of the rich interview data, and I worried about the integrity of my interpretations. Discussing my research 'out loud' in supervision, with other researchers, and keeping a reflexive journal helped me to challenge my thinking. For example, as I reviewed the IPA narrative I realised that the theme 'poor therapy has good aspects' was a step too far, and renamed this 'experiencing good aspects of therapy'. The analysis of the interview data was a messy process and a number of tensions arose, for example data could be coded in numerous ways; themes overlapped; it was difficult to decide which rich data to use; and it was challenging to 'clean up' rich data and also to remove it from its context. The findings present a compromise, a moment in time, and an insight not a truth. I wish to disseminate my research and the thematic analysis will enable me to comply with the word count restrictions for journal articles. I hope that by giving voice, albeit thematically, to my participants makes a contribution to acknowledging

their experiences and informing practitioners. I can write the stories of my research in other ways for different audiences.

As an 'insider', I tried to avoid imposing my experience on participants through, for example, questions asked or probing. In the interviews, I was conscious of remaining in my researcher role, and I was mindful of being fully present and empathic, and treating participants with dignity and respect. While Internet research avoids the intrusion of 'cues' which may influence participants, it is possible that being empathic, even in a non-verbal way, influenced participants. I tried not to make assumptions about participants' meanings. For example, when Caroline spoke about her need for safety, I explored her meaning as follows:

Researcher: "How do you decide if something is safe or not, what happens?"

Caroline: "I feel a sense of freedom. I think when I feel safe, I feel free. If I don't feel safe I feel confined, as if I've been boxed, as if I'm chained, and I need to be alert. If I feel safe then I feel free to be able to say whatever it is that I want to say. And also there's a freedom of being able to say exactly how I want to be able to say it and not having to worry about how it's going to be received at the other end".

I did not disclose my experience of PT as a client, but the following presents an example of other choices I made:

Olivia: "We [therapists] get to the end of some sessions and we think 'oh I don't know if that went alright'. Well I do [laughs]".

Researcher: "I do too".

My conscious decision to 'meet' Olivia was based on ethical considerations. I had no wish to replicate her experience of therapy so that I could pursue a research agenda at all costs. I attempted to foreground ethical considerations at all times, and tried to remain aware of my power as a researcher during the interviews. I did not ask participants why they had sought therapy to avoid causing unnecessary distress but some participants spoke of this anyway, and I tried to be as sensitive as possible in the timing of my questions to refocus on the research question. I tried to avoid creating a "hit and run" experience (West, 2002, p. 264).

3.9 Summary

This chapter has identified the philosophical considerations informing this research, and outlined the role of the researcher. The methodology and methods used to carry out this research have been presented, and attention has been given to quality, ethical, and reflexive issues. The next two chapters present the findings of stage one and stage two of this research respectively.

Chapter 4: Findings of the qualitative survey

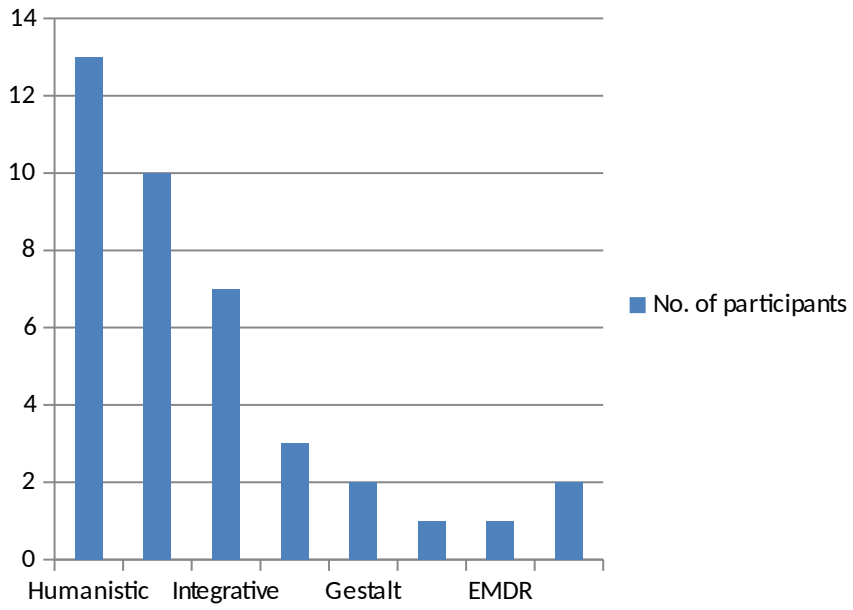
This chapter will present the findings for stage one of the research, the online qualitative survey, to answer the research question: *What is the experience of clients who prematurely terminate therapy?* The purpose of the survey was to gain an overview of clients' experiences of PT, and to recruit participants for stage two of the research. The sample is presented in section 4.1, and the thematic analysis of the open-ended questions is presented in section 4.2. Three main themes were identified. The first theme of 'feeling dissatisfied with therapy' is presented in section 4.2.1; the next main theme of 'client becomes unable to continue therapy' is presented in section 4.2.2; and the final main theme of 'communication about the premature termination' is presented in section 4.2.3. Section 4.3 summarises this chapter.

4.1 The sample

Of the 50 responses, 80% were usable. Of those that were not usable, seven participants did not answer any questions beyond the questions asked to situate the sample. Two participants referred to an experience of prematurely terminating following an assessment appointment, and this did not match the definition of PT used for the study. Further, one participant lived outside of England, which did not meet the inclusion criteria for the study. It is not possible to indicate a return rate for online surveys. The 40 usable responses included 19 participants who indicated that they would be willing to be interviewed for stage two of the research. All participants indicated that they were qualified therapists and lived in England. Appendix 13 presents contextual information collected from the purposeful sample.

Nearly 88% (n=35) of respondents were female. Almost 73% (n=29) were in the age range 31 to 50 years; 7% (n=3) were in the age range 18 to 30 years; and 20% (n=8) were in the age range 51 to 70 years. Participants were asked what type of therapy they had. Of those who answered, 33% (n=13) of participants reported having humanistic therapy; 26% (n=10) had psychodynamic therapy; and 18% (n=7) had integrative therapy. Figure 5 presents the full range of responses. One participant did not answer this question.

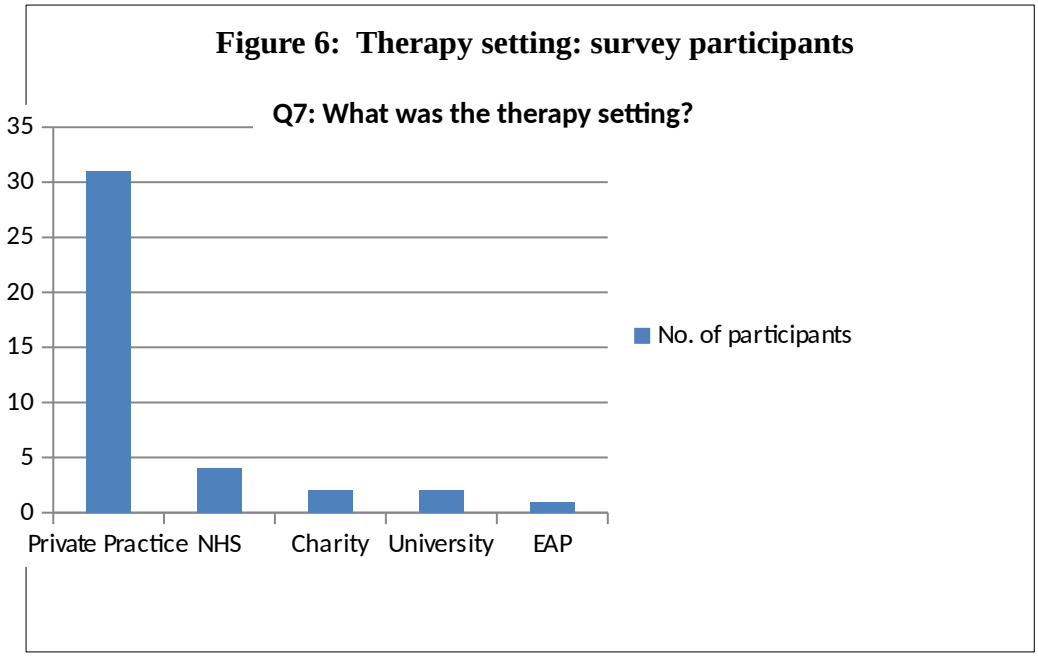
Figure 5: Type of therapy: survey participants



Key: EMDR = Eye Movement Densensitisation and Reprocessing

Almost 78% (n=31) of the experiences of PT related to experiences in private practice, and 10% (n=4) referred to experiences in NHS settings. Figure 6 presents the full range of responses.

Figure 6: Therapy setting: survey participants



Key: NHS = National Health Service; EAP = Employee Assistance Programme.

Most participants identified a time point when they decided to drop out as shown in Table 3.

Table 3

Point of premature termination: survey participants

Point of deciding to terminate	Number of participants
Session 2	4
Session 3	5
Session 4	5
Session 5	4
Session 6	4
Session 8	2
Session 10	1
Session 14	1
3 months	1
10 months	1
1 year or more	5
Other	7

The 'other' responses were textual and form part of the thematic analysis of the data. Participants were asked how long ago they prematurely terminated therapy. Fifty-five percent (n=22) of respondents terminated between one and five years ago; 37.5% (n=15) terminated more than five years ago; and 7.5% (n=3) terminated less than one year ago. Participants were asked how many experiences of therapy they have had. Of those who answered this question, 87% (n=33) reported more than two experiences; 8% (n=3) reported one experience; and 5% (n=2) reported two experiences. Two participants skipped this question. Participants were asked if they had sought further therapy after the PT. Of those who answered, 77% (n=30) of participants did seek further therapy; 23% (n=9) did not seek further therapy; and one participant did not say. Participants were also asked how many times they had prematurely terminated therapy and of those who answered, 79% (n=30) reported once; 16% (n=6) reported twice; and 5% (n=2) reported more than twice. Two participants skipped this question.

4.2 Analysis of the open-ended questions

The responses to the open-ended questions varied in length, but were mainly 'thin' data. The data were analysed using thematic analysis for the reasons discussed in section 3.4.1, and resulted in three themes and eight sub-themes as shown in Table 4.

Table 4

Table of themes: survey participants

Main theme	**Sub-theme**
4.2.1 Feeling dissatisfied with therapy	4.2.1.1 Expectations not met 4.2.1.2 Issues with the therapist 4.2.1.3 The process of therapy 4.2.1.4 Lack of progress
4.2.2 Client becomes unable to continue therapy	4.2.2.1 Client willingness to pursue therapy 4.2.2.2 Considering environmental factors
4.2.3 Communication about the premature termination	4.2.3.1 Client decides to leave therapy 4.2.3.2 Therapist response to premature termination

These themes and sub-themes are now presented.

4.2.1 Feeling dissatisfied with therapy

This theme related to a range of unhelpful experiences in therapy.

4.2.1.1 Expectations not met

Some participants referred to experiencing dissatisfaction as they realised that therapy was not meeting their expectations. Participant 4 gave an example of expectations not being met in: "she said that maybe I wasn't ready to be discussing the things I was. It felt like she was avoiding me or intimidated by my problem". Participant 18 felt that therapy was not what she had expected when she recalled, "I felt she had her own agenda with some of the questions she asked but she did not explain this to me".

Some participants were able to tell their therapists that their expectations were not being met but this was after they had made the decision to prematurely terminate therapy, for example "I told my therapist I would not be returning as I felt let down" (Participant 40).

Some participants expressed dissatisfaction with the modality of therapy. Participant 26 reported that "too much homework" was given and said, "CBT wasn't right for why I sought therapy. I don't feel the NHS accommodates many issues clients present with". Participant 18 became dissatisfied because "the style of therapy felt a bit woolly whereas I needed something more concrete". On the other hand, Participant 16 felt the therapy was too structured and that the "therapist was basically taking me through a workbook I could have done independently". For Participant 7, her preference regarding modality emerged during her therapy and she realised that "I had studied a different type of therapy on my training course and felt that it suited my trauma history more".

4.2.1.2 Issues with the therapist

Participants reported feeling concerned about the therapist and therapists' use of power. Participants felt that the therapist was not the right fit (Participant 7) or did not share similar views (Participant 34). Other participants referred to being dissatisfied by the therapist's manner and/or training. For example, Participant 33 wondered about her therapist's experience when she recalled, "I did not feel as though my therapist was as experienced as she claimed to be". Participant 2 felt that her therapist was "coasting in sessions". Some participants expressed concern about the therapist's ability to help, for example "I knew I could not work with the therapist because of what was going on for him" (Participant 12), and "I thought the therapist looked tired and wasn't listening to me" (Participant 5).

Several participants experienced a poor therapeutic relationship, for example "I felt the lack of relationship between me and the therapist" (Participant 30). Participant 19 referred to "a general feeling of dissatisfaction and annoyance with therapist who didn't seem to care about what I said". Participants referred to feeling "uncomfortable" (Participants 25 and 28); experiencing the "therapist's lack of empathy" (Participants 9 and 35); not feeling listened to (Participant 26); feeling that "a gentler approach would have been good" (Participant 37); and feeling that "I could not trust her" (Participant 40).

Several participants were unhappy about their therapists' use of power. Participant 37 experienced the "therapist throne" as oppressive. Participant 9 recalled that "the therapist told me she wanted me to stop my training otherwise she would not work

with me anymore", and when she decided to leave she was denied an ending session. Participant 8 wanted her therapist to accept "my belief that I hadn't had any sexual trauma was okay (especially as I had no signs of any!)". She found it unhelpful that her therapist was also her supervisor and line manager. Therapist self-disclosure was experienced as an inappropriate use of power. Participant 22 felt that "the therapist did most of the talking. She was more interested in telling me all about herself".

Other participants referred to experiences that were ethically dubious. On arrival at her session, Participant 32 was told by her therapist that "he'd had a call from a suicidal client he needed to see more urgently. When I left the session after 20 minutes, feeling unimportant, said suicidal client was in the waiting room, whose confidentiality had been grossly breached".

4.2.1.3 The process of therapy

Participants referred to feeling anxious by what appeared to be inappropriate interventions. Participant 30 experienced the poor timing of an intervention and recalled, "the therapist asked me at the end of a session if I had ever been sexually abused". She went on to explain that "the therapist's question reignited an old anxiety that I had been sexually abused by my father, and subsequently forgotten it". Participant 8 found it unhelpful and of concern "when he [the therapist] told me I had a repressed sexual trauma which could only be worked on if I had bodywork on my naked pelvis". Participant 37 experienced dissatisfaction when her therapist suggested an intervention that she was not willing or ready to agree to and recalled, "I remember the therapist wanted me to lie down on a sofa. I really didn't want to. I felt so vulnerable already". The pacing of therapy also created feelings of dissatisfaction. Participant 13 felt that "the work became too intense too quickly and I felt that it was starting to overwhelm".

4.2.1.4 Lack of progress

Participants reported feeling stuck, for example "after two years I started to feel stuck and thought about dropping out" (Participant 5). Participant 12 felt that "it was a waste of my time and money". Even though participants realised that ruptures could have been addressed, they were reluctant to do so if no progress was being made:

> "I would have liked her to reflect on some of the things and realise that she had got some things wrong; it would have been useful to explore some of it with her however I felt resentful about parting with any further money to see someone who ultimately was not helping me". (Participant 14)

4.2.2 Client becomes unable to continue therapy

4.2.2.1 Client willingness to pursue therapy

Some participants recognised that feeling unable to continue with therapy was related to their unwillingness to work on the material arising in therapy. Participant 1 was concerned that "I did not have the inner resources to tackle the issues being raised". Participant 13 reported that she "was undergoing too many changes at the time so for me to change also became too much". This unwillingness to work in therapy was not necessarily acknowledged at the time, for example "I realise now that I had become defensive when an intervention was suggested that touched a nerve! At the time I was unaware of this and I decided that I didn't like the therapist's approach" (Participant 20). Related to being unwilling to pursue therapy was an appreciation that PT was a developmental activity. Participant 39 recognised that she could exercise choice and leave therapy.

4.2.2.2 Considering environmental factors

Some participants referred to feeling helpless as financial and organisational problems intruded on therapy. Participant 3 recalled, "I ran out of money for personal therapy. I had quite a strong attachment to my therapist and was upset about this". Participant 36 also ran into financial difficulties and recalled, "I would have liked to continue if I could afford to". Even though her therapist understood about her reasons for PT, Participant 36 felt that "it would have been good if she could have offered further fee reductions but this was not possible".

Participants experienced "scheduling conflicts" (Participant 1), and difficulties with the organisation employing the therapist. Participant 11 felt conflicted and recalled, "organisational policy required calling the head office to book an appointment instead of booking with my counsellor which I found inconvenient and created inconsistency". He recognised that "the therapist was very beneficial, but policies outside therapist control" and added, "in another setting I would gladly work with the same therapist".

4.2.3 Communication about the premature termination

This theme identifies how/if participants expressed their dissatisfaction and communicated their PT to their therapists, and how/if their therapists responded.

4.2.3.1 Client decides to leave therapy

Participants presented a number of ways of communicating to their therapists, and most participants were unwilling to express their dissatisfaction. Participants described a range of vague communications including:

"I sent an email making an excuse" (Participant 35);

"I did not return for future sessions but looked elsewhere for the required therapy" (Participant 34);

"I just pretended I felt ok" (Participant 25);

"Said I'd be in touch" (Participant 19).

Some participants told their therapists that they were unhappy with the therapy. Participant 33 recalled, "I told my therapist that the therapy was not working for me", and Participant 13 "contacted the counsellor and talked it through with her and we both decided it wasn't the right time for me". Other participants also reported that they talked it over with the therapist (Participants 7 and 21).

Most participants did not regret prematurely terminating therapy, although some participants recognised that issues remained unresolved. Participant 9 recalled "a good ending would have helped me to internalise something healing, instead I was left with a deep mistrust towards therapists which I was unable to overcome". Participant 30 recalled, "I only wish I had never started it as it provoked a period of depression"; and Participant 37 wished "I had the guts to complain". PT was experienced as painful by Participant 3 who ran out of funds for therapy.

4.2.3.2 Therapist response to premature termination

This theme identifies how/if therapists responded, and how participants experienced this. A number of therapists did not respond to participants when they prematurely terminated therapy, or were ambivalent, for example "she wasn't bothered, said it was up to me and not to worry about her as she had a waiting list of clients

(Participant 22), and “I was left feeling as though she did not care” (Participant 23). Several participants reported that they wanted an acknowledgement from their therapists.

Therapists, who did respond, did so in a number ways. Some were caring, for example “was ok with it – checked in with a phone call after 6 weeks to see if I was ok” (Participant 25); “she was quite understanding and helped me with my decision” (Participant 7); “she was fantastic and advised that I could return at a late date if I needed to” (Participant 13); and “she was helpful at the time, can’t think of anything else she could have done” (Participant 3). Other therapists tried to persuade participants to remain in therapy, for example “they had no choice but to accept my decision, however, they tried to convince me to continue at least until 6 weeks” (Participant 33), and “she asked me to carry on and work through it with her” (Participant 30). Some participants felt that their therapists took the news badly, for example “said I needed more therapy” (Participant 19); “I was sent a bill and letter to pick up my drawings otherwise she would get rid of them” (Participant 9); “she seemed angry” (Participant 37); and “challenged me in supervision stating that I was running away and that good therapists look at their blind spots” (Participant 8).

Some participants were happy with the response from their therapists and some recognised that the therapy was beyond repair, for example “no words could rescue this situation” (Participant 40); “I’m not sure that my therapist could have said anything helpful. I felt as though she was just trying to keep me attending for her benefit and not mine” (Participant 33); and “trust had been broken at that point” (Participant 32). Others experienced a lack of closure and wanted their therapists to acknowledge that “what I wanted was fine” (Participant 39). Some participants felt that an acknowledgement from the therapist that therapy had not worked could have provided closure, for example “an apology and acknowledgement that it had been bad practice” (Participant 30); “a reply of some description and a willingness to hear the rupture and work to repair it with me. Wouldn’t have went back given her ignorance to sexuality but it could have been a better ending” (Participant 24); “acknowledgement that the fact that things hadn’t worked out was down to both of us, not just me” (Participant 29); and “I felt it would have been better to explore my experience of counselling, to address my disappointment and, yes, my resentment at having paid a lot of money for a service I found unsatisfactory” (Participant 22).

Some participants expressed a desire to repair the rupture but were not offered this opportunity, and Participant 15 felt that the therapist could have been "more open to feedback/adjustments". However, the invitation from the therapist to discuss concerns was not necessarily taken up, for example "she questioned if I thought she was unprofessional. I told her these were not words I would use, as they have huge implications in terms of therapy" (Participant 40). Even though most participants knew that they would not return to their therapists, this did not mean that they no longer had expectations of their therapists, for example "he could have suggested other therapists" (Participant 19); Participant 27 felt that the therapist could have offered an opportunity "to speak to me informally without charge"; and Participant 5 felt "a phone call to talk it over" would have been a helpful response.

Finally, several participants reported going on to have successful subsequent therapies, for example "I was fortunate to go to a counsellor who actually helped me to explore issues and unpack a lot of repressed feelings and emotions. She restored my faith in therapy" (Participant 22).

4.3 Summary

This chapter has presented the findings from the online survey, and provide an overview of the experience of prematurely terminating therapy for participants who took part. The next chapter presents the findings of the interviews.

Chapter 5: Findings of the interviews

This chapter presents the findings of the analytic process described in Chapter 3 for the second stage of the research. The three superordinate themes derived from this analysis are linked by the temporality of the experience, and address the research question: *What is the experience of clients who prematurely terminate therapy?* and the second aim of the research: to understand the experience of dissatisfaction when this is given as a reason for prematurely terminating therapy. Each superordinate theme is representative of all participants' experiences, however, not all participants are represented in the eight subordinate themes. Table 5 presents the themes.

Table 5

Table of themes: interviews

Superordinate Themes	**Subordinate themes**
5.2 Feeling confused	5.2.1 Therapy is a performance 5.2.2 Diminishing the self 5.2.3 Experiencing good aspects of therapy
5.3 Losing hope	5.3.1 Evaluating therapy 5.3.2 Evaluating the therapist 5.3.3 Feeling disempowered by therapist
5.4 Acknowledging dissatisfaction	5.4.1 Parting ways 5.4.2 Enduring impact

First, brief pen portraits of the participants are presented in section 5.1. Thereafter, each superordinate theme and the related subordinate themes, including rich data from participants, are presented. The first superordinate theme of 'feeling confused' is presented in section 5.2; the next superordinate theme of 'losing hope' is presented in section 5.3; and the final superordinate theme of 'acknowledging dissatisfaction' is presented in section 5.4. To improve the readability of the rich data and because of the limited word count for the thesis, the extracts presented have been 'cleaned up' by, for example, removing 'errmm' and 'you know' and 'sort of'. However, repetitions have not been removed where they appear to reflect the sense making of participants. Section 5.5 summarises this chapter.

5.1 Pen Portraits

The participants

The six participants volunteered to be interviewed following the completion of an online survey. All participants were therapists living in England. All accounts described experiences of therapy in private practice with a female therapist. Pseudonyms have been used.

Sophie

Sophie is a qualified integrative therapist in the age range 31 to 50 years. She was qualified at the time of the therapy she prematurely terminated. She described an experience of therapy with a person-centred therapist that lasted two years. The experience took place seven years ago. The therapist was highly recommended to her by a friend. Sophie kindly offered that the interview could take place at her home. The interview lasted for 69 minutes.

Alison

Alison is a qualified integrative therapist in the age range 51 to 70 years. At the time of the therapy she prematurely terminated, she was in her second year of therapy training. It was a requirement of her course to have six sessions of therapy, and she attended six sessions of therapy with a humanistic therapist. The experience she described happened three to four years ago. Her therapist worked in a community centre. She found her therapist via an online therapist directory. Alison kindly offered that the interview could take place in her therapy room, situated in her home. The interview lasted for 63 minutes.

Caroline

Caroline is a qualified integrative therapist in the age range 31 to 50 years. At the time of the therapy she prematurely terminated, Caroline had just started her therapy training. Caroline had 100 sessions of therapy with a humanistic therapist four or five years ago. Caroline kindly offered that the interview could take place at her work place. The interview lasted for 63 minutes.

John

John is a qualified person-centred therapist in the age range 51 to 70 years. At the time of the therapy he prematurely terminated, he was at the second stage of his therapy training. He found his therapist via an advertisement on the notice board at his training institute. He attended four of the six sessions he was required to complete, with an integrative therapist five or six years ago. John kindly offered that

the interview could take place at his work place. The interview lasted for 59 minutes.

Olivia

Olivia is a qualified integrative therapist and is involved in training therapists. She is in the age range 31 to 50 years. Olivia described two experiences of prematurely terminating therapy, and these are referred to as therapy 1 and therapy 2. In therapy 1, she attended four or five sessions 18 years ago with a person-centred therapist. She found her therapist via a list provided by a counselling organisation. During this therapy, she was not a therapist or training to be a therapist. Her experience in therapy 2 took place five years ago when she was a qualified therapist. Olivia kindly offered that the interview could take place in her home. The interview lasted for 66 minutes.

Emma

Emma is a qualified integrative therapist in the age range 31 to 50 years. She attended 16 sessions with the integrative therapist she dropped out with, three years ago. Emma was a trainee therapist at the time. She found her therapist via an online therapist directory. Her therapist had an advanced status with a professional body and trained therapists in a University. The interview took place in an interview room in civic offices that were convenient for Emma to reach. The interview lasted 63 minutes.

5.2 Feeling confused

The findings indicate that the initial stage of therapy, for all participants, was characterised by a period of inner conflict. This theme represents the inner dialogue the participants engaged in, to try and make sense of an experience that was confusing. There are a number of dimensions to this superordinate theme represented by the following subordinate themes.

5.2.1 Therapy is a performance

Five participants described a process of trying to make sense of their role in therapy. Emma was the exception. This was a consuming process and distracted the participants from why they had gone to therapy. The participants were reluctant to trust their initial experiencing and persisted in therapy. The theme was represented in different ways by the participants.

Sophie felt under pressure to align with her therapist:

> "I felt in that therapeutic relationship, I felt angry a lot of the time. I always had a sense with Beth [the therapist] that she thought she was two or three steps ahead of me and she was just waiting for me to catch up. So she would often say things like 'and that's because'….and I ended up feeling [pause] that I was almost trying to sort of second guess the answer that she wanted me to come up with". (Sophie)

In this extract, Sophie recognises that she felt angry about the therapeutic relationship, yet she remained in the therapy for two years and tried to make it work. She silenced her reservations about the way her therapist was working and it seems that she performed, rather than engaged, in therapy. Her attempt to please her therapist or to be a 'good client', rather than being herself, was reinforced later in her account, when she said, "and you know I got a long long way away from myself in those sessions".

Some participants described remaining passive in therapy. Caroline remained in therapy for a further 65 sessions after deciding it was not meeting her needs. She was aware that specific interventions made by her therapist were unhelpful:

> "She would talk to me about, or at me, it felt, about, 'well you know this is what you'll experience and these are the sort of thoughts you might think' [pause] and I used to think, 'no I don't, no that isn't'. It's almost like she'd read a book on childhood sexual abuse and that all victims feel this so obviously that's what you must feel". (Caroline)

Although Caroline is clear that her therapist was wrong in this extract, she did not tell her therapist that the intervention was incorrect. While it seems that Sophie was trying to please her therapist by fitting in with her therapist's worldview, it appears that Caroline decided to remain silent.

This sense of remaining passive while trying to understand therapy was also shared by Alison as she recalled, "I really shouldn't have gone back after the first one really because I didn't feel comfortable from the start". Alison tried to make sense of her experience by referring to popular discourses about therapy when she said, "I hadn't had therapy before so I thought, 'oh maybe this is part of it or something'. I don't

know. I mean you hear about people going through turmoil in therapy. I thought 'maybe this is it'". Rather than listening to her doubts, Alison searched for a way to legitimise what was happening in her therapy. Similarly, John struggled to understand what was happening when he said, "actually for the first couple of sessions I kept it to myself. So once I came out I thought, 'what was all that about?' And I didn't really want to share it with anyone else". For John, therapy was a performance outside the room too, and this was an unsettling experience for him. He felt ashamed to tell anyone that he was still going to a therapy that was not working, and had to pretend to his wife that it was going well because it was expensive.

Some accounts referred to the 'routine' of therapy. In the following extract, Alison describes therapy as a routine she performed:

> "I'd just go into that room [pause] which was bizarre because it had a bolt on the door and that wasn't very good either. So, that just gave you a bad [laughs] from the start...I'd just go in there, she'd interrogate me and rape me and then chuck me out and I'd give her money for it and it was horrible". (Alison)

Caroline also referred to performing a routine and referred to the "saga of the cup of tea" and feeling forced to participate in the therapist's rituals. She felt obliged to drink the tea given to her by her therapist even though she did not want it. She even had to spend time exploring why she did not always drink the tea and whether it was the right colour, rather than working on her problems. She recalled, "It feels more like you're going along each week and just processing the last week rather than actually really doing anything in depth, and there were an awful lot of issues really that needed to be worked through".

The therapy routine was experienced differently by Olivia (therapy 1) because she was waiting for the therapist to help her. She recalled, "I can remember just looking at this person thinking, 'are you going to say anything?'". She referred to feeling 'frozen' and not knowing how to make use of therapy. She was unable to engage in therapy because she had no idea how to. Her inner experiencing was preoccupied with the therapist's performance rather than the reasons why she had gone to therapy. Unlike the other participants, Olivia saw it as the therapist's role to explain and facilitate the process.

In their talk about subsequent therapies, some of the participants felt that this was when "the real work started" (Alison), suggesting that the previous therapy was superficial. John felt that his therapist was not interested in him and "I was just there really to give her someone to talk to for an hour and to pay for the privilege". He felt that therapy was simply a "chat". His therapist used the sessions to talk about herself, and this silenced him. He recalled, "she hardly knows me, part of it was, is she dismissing what I might have to bring?". Caroline also felt her therapy lacked depth:

> "I'd had the feeling for quite some time really that this wasn't really, if I'm honest I think it was probably a good 30 to 35 weeks of therapy, probably even more, that didn't feel that it was therapy, just felt like a bit of a chat really". (Caroline)

5.2.2 Diminishing the self

This theme illustrates how participants blamed themselves for therapy not working, and/or made allowances for their therapists. All participants are represented in this theme.

Five participants felt they were at fault in therapy, and Alison was the exception. The following extract from Caroline presents her struggle:

> "I mean it wasn't good therapy, absolutely it wasn't, but it wasn't, at that time, I wasn't aware of what such a negative therapy it was. I wasn't getting anything. I wasn't getting anything [pause] negative but I was giving myself negative messages because I thought I wasn't doing a good job in therapy, so it fed into that part of me which is quite easy to feed into anyway, so it didn't take a lot to feed into that. So I felt I'd let myself down in therapy and I'd let her down in therapy". (Caroline)

Her repetition of "it wasn't" gives an indication of the strength of her dissatisfaction, and yet her conflict was sustained by her self-blame. She had assumed that the challenge in therapy would be related to working on painful material from her past, not trying to figure out the confusing aspects of her therapy. This resulted in her questioning, "is there something wrong with me that I can't do this?". Similarly,

Olivia (therapy 1) considered whether "I was wrong for not being able to talk" when therapy did not progress.

Self-blame was also a feature in other participants' accounts. Emma did not feed back to her therapist because "I suppose I wondered if I was wrong. I thought maybe that's just her particular style and maybe that's ok". Emma even blamed herself for her therapist hugging her when she reflected, "I suppose once she went to hug me I went with it…I have a tendency to go along with things". Emma recognised that she had made a big personal commitment in attending therapy. She was not earning much, the therapist's fees were high, and she lived out of the area, which added to the cost and time involved. It seemed like this had the potential to add to her inner conflict as she had invested so much in the process. Taking responsibility was also a feature of Sophie's account and she found a way to blame herself for what she perceived as her therapist's countertransference in:

> "And I take responsibility for what I invoke and bring into the room, and the themes of the stuff I was taking in were mother's stuff. I have a mother and a step-mother and both of those parenting models weren't great so I'm sure I evoked a lot of the feelings that were similar". (Sophie)

It seems that Sophie was unwilling to conceive that her therapist could be lacking, and she chose to diminish herself:

> "I would have thought she was in tune enough to have felt that something wasn't working in that session. Well I know that we all have tricky clients sometimes. I think that's how I felt. I felt like a tricky client". (Sophie)

It seems that it was difficult for some participants to feel confident about their experiences as they considered, 'is it the therapist or is it me?' Even John, who had reservations about his therapist early on, reflected:

> "I'm wondering did she think it was ok to do that [referring to the therapist's self-disclosure] because I haven't complained or I haven't made any comment about it, so she was comfortable doing that? But then maybe that's just reading too much into it. It was just some easy money. I just really don't know". (John)

While Alison did not blame herself, she still diminished her needs to try and make allowances for her therapist. She reflected, "I'm a fairly easy-going person". The extent of Alison's inner conflict was apparent when her feelings about her therapist were considered:

> "I didn't like anything about her really [laughs]. I don't even know why I went. Now I'm thinking about it, I think, 'oh God why did you go? Why did you go for six weeks? Why did you pay her for six sessions really?' How crazy, but, you know, I thought that things might change really". (Alison)

Interestingly, Caroline and John referred to the probability that their therapists worked well with other clients. Caroline suggested, "for someone else she could be a brilliant therapist". John was sure that his therapist "does fabulous work". Their adjectives describe outstanding therapists. This possibly strengthened their belief that they were at fault for preventing their therapists working well.

Sophie was the only participant who felt that her therapist was aware that she was not working well, and yet she persisted to diminish herself as she recalled, "I feel that she probably feels she didn't do her best work. I'm sure I didn't allow her to".

5.2.3 Experiencing good aspects of therapy

Three participants recalled positive experiences in therapy during the process of the interviews. Sophie reflected:

> "I'm remembering now another piece of work that I took in where she was helpful which I'd forgotten. So I'd had in my mind that the whole thing was unhelpful but there were elements of the work that were helpful". (Sophie)

In this extract, Sophie reframes her experience. She explained how her therapist had supported her feelings about a particular issue she took to therapy and concluded, "I can't fault her for that bit [laughs]. It's just the rest of it [laughs]".

Caroline recalled that her therapist helped her to relieve a physical symptom, "we managed to get rid of it [the symptom]….So that was a good thing that did happen within the therapy but apart from that it was quite tough going". Similarly, Emma was able to draw on positive aspects of therapy as she referred to her therapist's

manner, and recalled, “she did at times embody the core conditions. She was very much a warm and caring person”.

5.3 Losing hope

Overall, this superordinate theme explores how participants’ reservations about therapy developed. Their experiencing moved from a position of feeling in conflict, to losing confidence, and feeling dissatisfied. There are three interconnected subordinate themes.

5.3.1 Evaluating therapy

This theme demonstrates how participants realised that therapy was not meeting their expectations and needs, even though they were not necessarily aware of these at the start of therapy. This theme applied to all participants in different ways.

Some participants described a process of their needs and expectations emerging during therapy:

> “But of course at the beginning I didn’t really know what safety was and I didn’t know that safety was an issue for me. I didn’t know that was something important. It hadn’t entered on to my radar at that point what it was, what it felt like, or it wasn’t something that I’d ever really explored and I certainly didn’t with her”. (Caroline)

The absence of safety enabled Caroline to understand how crucial safety was to her in order to engage in therapy. Her “radar” was activated. She recalled feeling responsible for and burdened by a therapist who consistently used the therapy to self-disclose. Although Caroline became aware that her need regarding safety was not foregrounded at the start of therapy, she did have an expectation of therapy:

> “My expectation was that I could go to her and she would be able to show me what I needed to do, to find out what was actually wrong, or if there was anything wrong, to actually get a sense of who I was, to help me to get a fuller picture of who I was, what was actually going on for me”. (Caroline)

Caroline expected her therapist to be facilitative and to help her to understand herself. It took some time for her to realise that “I never got my needs met at all”.

Emma acknowledged that her expectations for therapy were unclear, however, throughout the sessions her expectations of what she expected from therapy emerged and she evaluated her therapy negatively. Sophie and Olivia (therapy 1) described similar experiences. Sophie knew that "I very much didn't want to be challenged or kind of pulled about" at the start of her therapy. As therapy progressed, she became increasingly dissatisfied that her needs were not being met. She explained, "I didn't have something that I wanted, that I felt I'd asked for by going, you're implicitly asking for that by going and that I'd paid a lot for. She was expensive". Her use of implicit suggests that there are unspoken rules about how therapy should be and what it should deliver. Even though Olivia (therapy 1) had little understanding of therapy, she still had implicit expectations, which were not addressed by her therapist. She recalled, "she didn't explain to me what counselling was about or that it could be a difficult process". Olivia "was pushed" into going for counselling by her employer. This created an expectation that counselling must be a helpful thing to do, but this was not her experience:

> "I can remember nothing being said. I can't remember how long it was for, but it felt like it was a long time and that's why I walked out in the end because I felt 'what am I paying my money for?' [laughs]. Well I wasn't paying, it was paid, but I thought, 'what's this about?'". (Olivia, therapy 1)

Unlike the other participants, John and Alison did not refer to having any expectations:

> "In the initial session it was, 'what would you like to gain from therapy?' I said, 'well actually I don't really know. I'm coming along here with an open mind…'. So she said, 'oh brilliant, ok a voyage of discovery', which sounded quite appealing". (John)

It did not take long for John to realise that the therapy was unhelpful, and that the "voyage of discovery" was about his therapist's life and not his.

Five participants described realising that therapy was creating problems. Sophie was the exception. As John evaluated therapy he realised, "it was just very unsettling and actually I felt I'd been put in a bad position". Alison also described feeling

"unsettled" by the therapy. She felt that she "had a few little issues" to work on. She described how the therapy made her lose confidence in herself:

> "I didn't believe looking in the mirror and doing that thing [the therapist had told Alison to look in the mirror and say to herself 'I believe in you', to cure a diagnosis of low self-esteem] was going to help me try and cure an illness I didn't have. I thought, 'I'll give it a go anyway' because I wasn't feeling right by that point. She unsettled me, unnerved me. I didn't know, I thought, 'maybe I have got low self-esteem and I didn't know I had it'. Logically I knew she was wrong but she'd upset me so much that I wasn't [pause] my right self and not able to trust myself for a little while". (Alison)

She went on to contemplate what might have happened if she had persisted in therapy as she reflected, "could it have got to the point where I could have fallen into depression?" Olivia (therapy 1) was feeling traumatised when she entered therapy. She recalled, "I think it probably made me withdraw more in myself, certainly made me more upset, and probably more confused as well". Olivia continued, "she [the therapist] made me feel worse and I just didn't think she was wanting to help me", and Emma "considered some of it quite damaging." Similarly, Caroline also recognised that therapy was adding to her problems. She recalled, "I came out of it probably more confused, [pause] more lost I think is probably the right word because I think it just gave me more stuff to deal with rather than relieving me of some of it".

5.3.2 Evaluating the therapist

The process of evaluating the therapist moved participants' experiencing from an expectation of competence before the therapy began, to confusion in the early stages, and then to clarity that the therapist's manner and/or approach was unhelpful. This theme applied to all participants in different ways.

Some participants were influenced by their therapists' qualifications:

> "I did look for the person who had the most qualifications. I remember that being quite important to me [pause] because I had a Master's. I wanted someone who was quite qualified, thinking that was really important". (Olivia, therapy 1)

At the time of Olivia's first therapy experience, counselling was not well publicised and there was no information online. Alison felt that the therapy location added to her therapist's credibility:

> "I'm not fully English and some of it's about my mixed heritage and she professed to have experience in that region and with issues of cultural difference, that is what she put up on the website, so that is what drew it to me. And the centre that she works in do lots of things for different cultures, so it was very much about cultural identity". (Alison)

John recalled that his therapist "had all the diplomas on the wall behind me and it was all very impressive". Emma also remembered credentials being an important factor in her choice and recalled, "I assumed that this was quite a good counsellor to choose". Sophie relied on a recommendation from a trusted friend in searching for her therapist, and Caroline did not say how she chose her therapist. What appeared to emerge as therapy progressed for the participants was a tension between a therapist who looked good on paper or sounded good through a recommendation, and their actual performance as a therapist.

Alison found her therapist lacking in warmth, and felt that "a bit of empathy wouldn't have gone amiss". She explained:

> "She just trampled over my feelings completely. I did contemplate contacting her professional body to say that I didn't think she should be working. That's how strongly I felt but I didn't actually go through with it because, I don't know why I didn't go through with it. I suppose I was traumatised by it". (Alison)

John was taken back by his therapist's manner:

> "She was quite flamboyant ...she'd sit round in her chair and hang her legs off and it just, it just, it's just this client. I don't know, it was almost like [pause] she wanted to be seen as a character, a larger than life kind of person". (John)

His repetition of "just" appears to indicate how diminished he felt. He appears to evaluate his therapist's professionalism. He wondered if the rules of being a

therapist change when you "reach a certain level". He recalled his increasing recognition of his therapist's unhelpful manner when his therapist corrected his French pronunciation incorrectly. John was a linguist, and his therapist's profile as an expert was diminished:

> "It came across as, 'look I'm the expert here. I'm the expert in everything. I'm even the expert in how you pronounce the name of this person', and I'm thinking, 'well actually the more you're coming across as I am the expert, you're coming across as I am not the expert'". (John)

Reflecting on the relationship John recalled, "we did hit it off, we did talk, we had conversations but that's what we had, we had conversations. We didn't have therapy".

Sophie experienced her therapist as coming "from a higher God-like place of 'well this is what's going on and can't you see that?'". Emma was surprised by her therapist's lack of attunement. A caring manner, however, was insufficient, as Caroline explained:

> "She did have an absolute genuine care. There was a part of her that could be very empathic. She really could at times get what you were saying but they were fleeting and then she'd almost think, 'ooh yeah look it's that', and go completely off on a tangent". (Caroline)

In this extract, Caroline describes a disappointing experience. Interestingly, Caroline was the only participant who described her therapist as kind. Despite her therapist being kind, Caroline realised that "she really doesn't have a clue". Caroline evaluated her therapist:

> "She's obviously not hearing what I'm saying. She's not really getting the full picture of what I'm saying and I feel I'm, she's out of her depth. It's how it felt, as if I'd brought up something she had no awareness around". (Caroline)

Her mixing of pronouns in "I feel I'm, she's" is interesting, and it is possible that the therapist being "out of her depth" made Caroline feel unsafe.

Some participants found their therapists' interventions confusing:

> "Well, what I wanted was the basics really. That's why I asked for a person-centred counsellor. I wanted someone who could hear me, who could just sit alongside me and bear witness to everything I was bringing without trying to analyse it, without coming up with [pause] answers that to me seemed quite random". (Sophie)

The therapist's interventions were inconsistent with a person-centred model of therapy. Emma wondered if her therapist was "making some kind of botched attempt at re-parenting me". She explained:

> "I was having a bit of a slagging off of my parents at some particular things that they've done, and there was some point where I think she seemed to join with that and I remember thinking, but again didn't feed it back, something like 'you're crossing the line now'". (Emma)

Her metaphor "crossing the line" illustrates Emma's increasing confidence that her therapist was not meeting her expectations. Emma also recalled her therapist making assumptions: "she reckoned my mum had a personality disorder and [laughs] I just thought, 'how can you possibly know that?'". Olivia (therapy 1) described how her therapist denied the extent of her loss by making assumptions in:

> "She asked me to bring in a photograph of my family so I took it in…and she was saying 'these are the most precious people in the world to me and I've got to look at the living'. And she kept going on about the living as well, and yet my dad was the person I was closest to, and I'm not close to my mum and I'm still really not close to her". (Olivia, therapy 1)

Caroline's therapist also made unhelpful assumptions:

> "I'll give you an example, I was abused as a child, and I was talking about that and she thought that because of that I had a problem with my body. So she gave me cream to rub into my skin to get me used to working with my body [pause] and that felt completely inappropriate". (Caroline)

5.3.3 Feeling disempowered by therapist

Five participants felt disempowered by the therapist in therapy. Olivia was the exception. They described experiences of the therapist having an agenda or using their power in unhelpful ways.

The following extract from Alison illustrates her feelings of powerlessness:

> "I was keeping a journal for Uni and it [the journal] kept saying 'she's not, she's not listening to me, she's not listening to me, she wasn't listening to me'. She had an agenda, that's what I felt, she had an agenda". (Alison)

Alison turned to her journal to process how she was feeling. Her repetition of 'not being listened to' amplified her sense making. The change of tense from "she's" to "she wasn't" possibly gives an insight into Alison's experiencing as she gained clarity and made her therapist 'redundant'. Alison wanted to work on issues of cultural identity in her therapy but her therapist diagnosed Alison with low self-esteem and focussed on this. Alison reflected:

> "I was actually in a far more advanced stage than her of my own awareness of my cultural identity and I think it raised things for her maybe. That was my analysis [laughs] of her, that she couldn't deal with it". (Alison)

Despite this, her sense of feeling disempowered was evident in the following:

> Alison: "No, she couldn't deal with what I wanted to explore that's what I felt. She couldn't deal with exploring that so she tried to make out that I was [pause] what's the word I just said to you that she said to me, that I was?"
>
> Researcher: "Had low self-esteem?"
>
> Alison: "Low self-esteem that's it [laughs] I'd dismissed that. I asked all of my peers at Uni, 'do you think I've got [laughs] low self-esteem?' I asked my family and my friends. It bugged me for ages. I even tried the mirror thing just because I was thinking, 'maybe I have got self-esteem, maybe that will make me feel better'. Do you see what I mean? Even though I didn't believe it; I didn't believe I had low self-esteem".

She recalled what happened when she challenged her therapist:

> "She was very dismissive, very domineering. She wouldn't accept it. The minute I raised how I was feeling, 'oh well you would do, you know, because you've got low self-esteem' [laughs]. Basically it was going to be my fault whatever uncomfortableness I was feeling". (Alison)

She recognised that it was not possible to express herself in therapy. The therapist having an agenda featured in other participants' accounts. Sophie felt silenced when her therapist did not engage with certain topics. She realised that the therapist was dismissing what she wished to talk about and she evaluated this. She remarked, "her job is to understand why I think it's significant". Her experience was that her therapist knew best, and Sophie "didn't feel that we were on an equal footing at all". Not only was Caroline aware that her therapist had an agenda, but she had concerns about the purpose of this agenda:

> "I actually remember saying to somebody, 'I don't know, I don't think it's me who needs the therapy but I think my therapist might'. I actually made that comment to somebody at the time, 'I'm not too sure who these sessions are about, her or me'. So it did feel like she had her own agenda and it was nothing to do with me". (Caroline)

Some participants referred to ethical concerns about the way their therapists were working. In particular, self-disclosure was experienced as unhelpful:

> "So sometimes it almost felt like a role reversal in some [laughs] respects, and awful. So I knew far too much, I didn't particularly want to know anything about her. It wasn't because I was being unfriendly, it's just that I didn't want to know. She needed to be safe. I needed to know she was safe. So for her to be safe, I needed to not know what was going on with her. [pause] Of course now I know how awful that is. I wasn't aware of quite how bad that was then. But at the time, it just felt very very unsafe". (Caroline)

In this extract, Caroline describes the impact of her therapist's self-disclosure. Caroline moved from a position of being uncertain about what was going on, to realising how unsafe she felt. Her therapist tried to prevent her from leaving therapy:

> "I said next week will be my last session. And that's when she said to me,' I can offer you like another four, but they'll be free' and I'm just like, 'oh my goodness me'. So I felt obliged to take those because they were free and because [pause] this was a lot she was offering me and it would feel ungrateful. This is how it felt at the time, it would feel ungrateful not to take them. Again, it was about her needs not mine. I was happy to have gone there and then". (Caroline)

Caroline's wishes were not explored or respected. She recalled, "she would almost say, 'I'm a really nice person and because of that you're going to like me and you're going to get on with me'".

The self-disclosure by John's therapist was initially a source of confusion. As therapy progressed, his experiencing shifted from uncertainty to discomfort. He felt burdened:

> "I think it had gone too far by the time I realised what was going on. I don't really feel I should censor her and say, 'I think you're telling me too much' and in some ways I was becoming her therapist because she was coming up with all these worries that she couldn't share with anyone else and that didn't do me a lot of good". (John)

John appears to be drawing on his personal values and his expectations of a professional. His experiencing moved from confusion to clarity, and he realised that repair was not possible. He recalled, "I just got the impression that if anything went wrong it would be the client's fault and not the therapist's". Emma also found her therapist's self-disclosure unhelpful:

> "She announced that she still told her grown-up children that she loved them…I came away thinking 'why would she say that? How could that possibly help me that she tells her children that she loves them?' In fact it's just hurtful to have that". (Emma)

In this extract, Emma is trying to make sense of her experience. She was concerned about the difference in status between her and her therapist:

> "I don't think I felt particularly empowered or confident in myself at the time to question what she was doing…I suppose everything pointed to that this was a highly qualified, experienced person who knew knew what they were doing". (Emma)

5.4 Acknowledging dissatisfaction

This theme illuminates how the participants dealt with their dissatisfaction, and how this dissatisfaction permeated the PT itself, and had an enduring impact on all participants. The two interconnected subordinate themes are presented below.

5.4.1 Parting ways

This theme shows how participants prematurely terminated therapy. Three participants enacted an ending, two participants sent an email saying they were not returning, and one participant was congruent about their dissatisfaction.

Sophie described how she left therapy by enacting a planned ending. She recalled, "I had given her some warning. I can't recall to be perfectly honest, but probably I would have given her four weeks ending [pause] out of courtesy". She did not make her therapist aware that she was prematurely terminating therapy, and reflected, "I dropped out of therapy. I didn't work towards an ending". Interestingly, there are two strands to how she dealt with this. Firstly, she followed what she perceived to be therapy etiquette. Her personal values informed how she dealt with her ending. Secondly, she tried to protect herself from "being told off". Even though Sophie exercised her power by performing an ending, this did not obscure the enduring power of the therapist. Her ambivalence towards her therapist is clear in the following extract:

> "I remember her face because she'd obviously thought I was giving her a gift but I was just returning the book, and her face sort of lit up with this appreciation of this gift, and again, I think this was me getting my power back, and I thought, 'no you're not getting a gift from me because I don't want to give you anything. I'll give you back what's yours and no more and it was very much that'". (Sophie)

It appears that the therapist had no insight into Sophie's process, which intensified the performative quality of the ending.

The enactment of an ending was forced on to Caroline. Even though she had previously told her therapist that she wanted to end, her therapist assumed that there was a financial problem. Caroline felt trapped because it was clear that she still had issues to work through and she did not want to hurt her therapist. Caroline described the final session as "excruciating". She recalled, "and I was just sitting there, 'oh God roll on, roll on, roll on 20 past 10 and I can go'". In this extract, Caroline describes how powerless she felt even when she exercised her power. Her repetition of "roll on" indicates just how challenging performing an ending was. As in Sophie's termination, the therapist seemed unaware that Caroline was dissatisfied. John enacted his ending differently. He performed perceived therapy etiquette by thanking his therapist and making an excuse to prematurely terminate. He recalled, "I said, 'well it's been very nice but I'm not sure that this type of counselling is for me. I'm going to look for a different kind of therapist. I hope you don't mind'". Like Sophie and Caroline, his perception of his therapist's power was foregrounded even as he reclaimed his power. He explained further:

> "I think I was more trying not to hurt the lady's feelings, or get her antagonised, or to say that I didn't really find that I was getting any benefit from it. I was probably being more sensitive to her than she was being to me and my needs. She had all the qualifications and I had nothing". (John)

Alison and Emma emailed their therapists to say they would not be returning. In both cases, this followed a break in the therapy.

The only participant who was congruent with her therapist about her reasons for prematurely terminating therapy was Olivia (therapy 2). She drew on her first experience in therapy to explain why she thought this was important:

> "The fact that I walked out [in the first therapy experience] and I felt even worse by the counsellor not contacting me…I thought, 'well actually if you're going to stop the sessions you should let the counsellor know and let them know why', and really, for me, her approach just didn't suit me". (Olivia, therapy 2)

Unfortunately, this was not a positive experience for Olivia. She recalled, “she put it all back on me that it was me that was stopping the process because I was expecting too much from her”.

This was a confusing experience for Olivia:

> “I feel if the client actually tells you they’re dropping out it’s a really big thing because for me, when I didn’t tell them, [pause] I think probably it left me, I was probably scared of not telling them. So for a client to say, ‘I’m dropping out because it’s not working for me’ is quite a big thing for a client, isn’t it?”. (Olivia, therapy 2)

This extract shows how this experience created a further loss of trust for Olivia, not only in the therapy but in herself. Her use of “it left me” suggests a state of inner conflict when she did not work through an ending with a therapist. There was an expectation by Olivia that doing something different in her second therapy experience would prevent this from happening again.

The participants described a mixture of feelings when they prematurely terminated therapy. Sophie recalled, “when I did leave and the final session and back in the car and heading home, just the relief of, I don’t have to do that anymore”. For Sophie, therapy had been endured. She reflected, “and when I did drop out of therapy with her, that sense of getting my power back was very, very strong”.

Caroline was also relieved to leave therapy. She recalled, “I was just really, really glad to be away because it did feel like I’d been trapped”. Alison’s feeling of relief was short-lived. She recalled, “it was a relief, but then again I thought, ‘oh God, I’ll have to go through all of that again, telling someone new everything from the start’”. Emma reported a similar experience. She reflected, “you just walk away chuntering under your breath or feeling dissatisfied that you didn’t get what you had hoped you would get”. The way the therapist dealt with John’s decision to prematurely terminate made him feel relieved and annoyed. His therapist responded in a dismissive way. He recalled, “there was fine [slaps palms on knees] bye. That’s your choice”. John reflected on how he felt about this, “a little bit the wind out of my sails. I thought, ‘well that’s that then, that’s all I mean, I’m the disposable client’”. Olivia was left feeling angry after both of her experiences of PT. She felt

uncared for by the first therapist, and told off by the second therapist. None of the participants indicated that they regretted leaving; in fact John and Emma wish they had done so earlier.

5.4.2 Enduring impact

This theme applied to all participants in different ways.

Three participants appeared to voice ethical concerns about their therapists:

> "I think probably ever since, that has rankled a little bit with me…it just seemed wrong. And other people have told me that I should have made a formal complaint and all the rest of it but I don't want to do that but it felt a little bit unsettling even now thinking about it". (John)

John's experience of prematurely terminating therapy still had the potential to unsettle him. This suggests that he might be wondering about whether he could have dealt with the experience differently. Alternatively, he may be concerned about other clients who see this therapist, as earlier in the interview he said:

> "I didn't want it to reflect on me that it was kind of sour grapes or some kind of reflection on me that I would make some disparaging comments about her, so I just never said who it was. I thought, 'it didn't work for me though but I wouldn't want to put anyone else off'". (John)

John did not complain about his therapist's behaviour. It is possible that this is what is unsettling him now. This was a feature of other participants' accounts too. Even now, Alison refers to there being a "twingey thing". She explained, "that's the thing about therapy isn't it, because then you think, 'well she did see something, she's a therapist, she saw something. What did she see?'". Although Alison was clear that she did not have low self-esteem, she still struggled to make sense of her therapist's intervention. She had enduring concerns about her therapist:

> I don't think she should be working, I still don't. I did actually look her up and saw that's she's working with children now. I was like, 'oh my God I can't believe that now, that she's moved on to a more vulnerable group' [pause] so [pause] she moved on to more vulnerable people [pause] which obviously means she can dominate them a bit more". (Alison)

Emma had similar concerns about her therapist, and recalled, “I suppose I have a thing of being a bit concerned if other people go to that person and spend lots of money on the therapy and have bad experiences”. She reflected, “and I’ve wondered a few times about writing to her or something to say, ‘well actually this is why I really ended therapy’ and I don’t know, I just haven’t bothered”.

The other participants experienced the enduring impact differently. Sophie recalled, “I think it made me feel quite sad for quite a long time”. Sophie’s sadness turned to anger when she encountered her therapist as an expert in other ways, such as writing letters in newspapers and working as an Agony Aunt. Sophie felt her therapist’s public profile was inconsistent with person-centred practice and reminded her that she did not get “what it said on the tin”.

Caroline also felt angry. She recalled, “I did feel quite angry. Once I think I’d realised quite how [pause] inappropriate, how unprofessional, I’d have bouts of feeling quite angry at her when I think about how she was as a therapist”. Olivia (therapy 1) wondered if she mattered to her therapist after she walked out of her session:

> “I wonder really [pause] what happened in that counsellor’s mind? And I wonder if she really, and I don’t know, part of me thinks, I wonder whether she was upset about it or whether she just didn’t care because her next client was coming along”. (Olivia, therapy 1)

Her use of the present tense in “part of me thinks” suggests an enduring preoccupation with the failed therapy. Olivia also felt angry and this anger lasted several years. She recalled, “I think I stayed quite angry about the whole process really until I started training to become a counsellor”.

For some participants, having a successful subsequent therapy was important in making sense of the PT. For Alison, it helped her to appreciate the value of therapy otherwise “I would never recommend counselling to anyone”. A loss of confidence in therapy was experienced by some participants. Sophie reflected, “it’s easier now thinking about Beth [her therapist] because now I’ve had a very positive experience [pause] which is good [laughs] because otherwise I would probably have thought all my therapy experiences weren’t that great”. “It’s easier now” suggests that it was

difficult for Sophie to even think about her poor experience. Emma still wondered whether therapy is worthwhile.

Even though some participants reported that subsequent therapy mitigated the damage caused by the therapy, the extent to which this was possible was limited. Alison explained, “I had a lot put right straight afterwards with further therapy so it hasn’t [pause] left me as damaged as it could but I still get upset thinking about those sessions”. Similarly, Olivia (therapy 1) reflected, “I think I was quite mocking of counselling for quite a while [pause] even though I did have a positive experience with someone afterwards”.

For Caroline, further therapy highlighted the poverty of her previous experience:

> “Yes I’m a victim of childhood sexual abuse but it wasn’t actually that, that was giving me the problem. It was actually my relationship with my mother that was giving me the biggest problems and she never picked up on that, not in 100 sessions”. (Caroline)

Caroline tried to make sense of this. She reflected, “you can’t do 100 hours of therapy and come out none the wiser. You need to be coming out knowing something more than you went with. And perhaps I knew a little bit more, but not 100 sessions worth.” Caroline used the distancing “you” to indicate her incredulity and reverted to “I” as she appeared to acknowledge how little she achieved in her previous therapy.

5.5 Summary

This chapter has presented the findings from the interviews, and has offered an insight into the six participants’ experiences of dissatisfaction, and illuminated the trajectory of this experience. From the participants’ accounts, it is possible to discern the complexity of this process and the lasting impact this experience had on them. In the next chapter I will discuss the findings of stage one and stage two of my research with respect to the literature.

Chapter 6: Discussion

This chapter will discuss the findings of the research in relation to the literature and relevant theories in order to answer the question*: What is the experience of clients who prematurely terminate therapy?* The aims of the study are:

- To gain an overview of the experience of clients who prematurely terminate therapy;
- To understand the experience of dissatisfaction when this is given as a reason for prematurely terminating therapy;
- To inform and thus help improve practice.

The data were collected in two stages. Stage one involved an online survey to provide a 'wide-lens' on the topic, and to recruit participants for stage two of the research. Stage two involved interviewing six participants to explore their experience of dissatisfaction in depth. Participants were therapists at the time of recruitment, although not all experiences referred to being in therapy while qualified or training to be therapists. The recruitment of therapists as participants was necessary because it had not been possible to recruit 'non-therapist' participants previously.

A position statement is offered in section 6.1. A summary of the findings is presented in section 6.2. The sample is discussed in section 6.3. There is an overlap in the findings from the two stages, not least because the interviewees also completed the survey, and so they are discussed together with respect to the literature to address the first two aims of the study. Section 6.4.1 discusses the experience of dissatisfaction. The theme of 'client becomes unable to continue therapy' is discussed in section 6.4.2. The theme of 'communication about the premature termination' is discussed in section 6.4.3. Section 6.5 considers the impact of participants also being therapists. The third aim of the study, to inform and thus help improve practice, is discussed in section 6.6. Section 6.7 discusses the dissemination of the research, and section 6.8 summarises this chapter.

6.1 Position statement

The findings from this research raise some challenging questions for practitioners. Crucially, the research has raised my awareness of the importance of being

transparent with clients throughout the process of therapy, and of recognising the importance of understanding clients' experiences. Recognising that clients may be confused about interventions or fail to understand their rationale has made me reflect on how to improve my practice to minimise these problems. The need to consider this thoughtfully was exacerbated by the fact that the participants in my study were also therapists and yet they did not question their therapists. This led me to three conclusions. Firstly, the power of the therapist is greater than I had imagined. If therapists are unable to question their own therapists, then how can I expect my clients to question me? Secondly, therapists as clients are not that different to other clients. Thirdly, I needed to find a way to engage with my clients in a process of feedback which felt less threatening than directly asking 'how do you feel therapy is going?'

It is likely that my fore-understandings (see section 1.5) have shaped the way I have carried out this research and my interpretations. Engaging in a process of cyclical bracketing has made me aware of beliefs I did not articulate in my opening positioning statement, for example my belief that endings in therapy are important. These beliefs should be taken into account in reading the following discussion, as another researcher may have focussed on other aspects of the research. It is also important to take account of the limitations of this research (see section 7.1) when reading this discussion.

6.2 Summary of findings

The findings from the online survey offer insights into the experience of prematurely terminating therapy. Three key themes were created from the analysis: 'feeling dissatisfied with therapy'; 'client becomes unable to continue therapy'; and 'communication about the premature termination'. Some participants described how their expectations for therapy were not met, and a lack of agreement between therapist and client about how therapy would proceed. Not only did participants report feeling dissatisfied with their therapists, but also with the process of therapy and a lack of progress. Some participants became unwilling to continue in therapy, or experienced external factors intruding on therapy. Participants described how they communicated their PT and how the therapist responded. A range of responses were reported. It was found that some therapists did not respond, and some participants found this unhelpful. Clients' experiences of therapists' responses to PT

has not been specifically researched before, and the findings provide insights into how therapists could manage PT if it occurs.

The findings from the interviews offer a detailed insight into the experience of dissatisfaction when therapy is prematurely terminated, and illustrate the convergence and divergence between participants' accounts. No existing research has been found which specifically explores this experience across a range of therapies. The themes were 'feeling confused', 'losing hope', and 'acknowledging dissatisfaction'. Key objects of concern across the accounts were power, respect and being professional, which suggest that these were key aspects of participants' lifeworlds. All participants reported an enduring impact. The findings illuminate the trajectory of the experience of dissatisfaction for the six participants, and show how participants' experiencing moved from confusion to realising that the therapy and the therapist were not meeting their needs. This experience was characterised by feeling disempowered by the therapist, and by participants remaining preoccupied with the process of therapy and/or therapists' behaviour rather than working on the problems which took them to therapy. Even when participants decided to leave therapy, this did not necessarily obscure the power of the therapist. The importance of understanding clients' experiences to minimise causing distress to clients, as far as this is possible, is made visible through reading the participants' experiences.

6.3 The sample

It has been suggested that data from online surveys should be regarded with caution because "a respondent may be influenced by a third party, intoxicated, consulting other sources of information or simply acting frivolously" (Bond, 2004, p. 9). Despite the fact that the survey was advertised to therapists, and it was felt that they would respond to research in an ethical manner, it is not possible to assess who did respond to the survey. Therefore, in order to 'sense check' the sample, the gender and age profiles of the survey participants were compared to the membership statistics of the BACP membership as at January 2016 (see Table 6). The rationale for this was that the BACP has the largest membership of therapists in the UK (Couchman, personal communication, February 2, 2016).

Table 6

Gender and age profile of survey participants and BACP members

Source of BACP membership statistics: Couchman, personal communication, February 2 (2016).

While the gender profile of the survey participants and BACP members are comparable, there is a considerable difference between the age range of the survey participants compared to the BACP membership: 80% (n=32) of survey participants were 50 years old or younger, whereas only 43% of BACP members fell into this age range. This finding is consistent with literature which suggests that younger participants are found in online samples (Gosling & Mason, 2015), and means that the findings of this research may not apply to older clients. All participants self-selected as having prematurely terminated therapy, and this avoided applying a definition of PT that the client might not agree with (Westmacott et al., 2010). Two survey participants did not know what type of therapy they received, and this has been associated with a negative experience in therapy (Crawford et al., 2016). This is a surprising finding given that the participants were therapists, and points to a need for this to be addressed clearly at the start of therapy.

The majority of survey participants and all interview participants reported experiences of prematurely terminating therapy from a private practice setting. The findings indicate that at least some counselling in private practice is paid for by the client, and that clients consider economic factors in decisions about remaining in therapy. This may partially explain the predominance of PT in private practice

settings in this study. It is possible that the fact that the majority of participants had to pay for therapy may have impacted on the findings. It is also possible that participants were more critical of their therapy because they were paying. It may be that the stress of having to pay for therapy impacted on participants' engagement in therapy. This is relevant for 'therapist clients' (Kumari, 2011) and 'non-therapist clients' (Bein et al., 2000). It may be that clients are more likely to persist in therapy if they do not have to pay for it. Interestingly, in Chatfield's (2013) study which involved participants receiving therapy in the NHS, it was found that therapy was attended "in order to be seen to be complying with what had been offered" (p. 55). This suggests that it might be easier for some clients to leave therapy if they are paying. Of the participants who indicated a time point at which they terminated therapy, nearly 73% decided to leave within eight sessions, and this is consistent with the literature (Garfield, 1994).

6.4 The experience of clients who prematurely terminate therapy

Across a range of studies, the reasons typically given by clients for prematurely terminating therapy are improvement; environmental factors; and dissatisfaction (Swift & Greenberg, 2015). It is surprising, therefore, that none of the survey participants referred to feeling improved in any of the experiences of prematurely terminating therapy. The early studies exploring clients' perspectives about reasons for PT contacted clients from a particular service (Acosta, 1980; Garfield, 1963; Pekarik, 1983b) and this may have introduced bias because past clients may have been unwilling to discuss their termination decisions for reasons of social desirability. A recent study using an online survey found that 'improvement' was not given as a key reason for PT by clients (Anderson, 2015). It is possible that in my study, an online call for participants to participate in a study regarding the 'premature' termination of therapy was more likely to draw responses from dissatisfied clients, and this is a limitation of the study.

6.4.1 The experience of dissatisfaction

Although dissatisfaction is often presented as a reason for PT (Acosta, 1980; April & Nicolas, 1997; Bados et al., 2007), research exploring clients' experiences of dissatisfaction is surprisingly limited. While dissatisfaction has been identified in some studies (Dickson, 2015) it appears sidetracked in others, for example Todd et

al. (2003) combined the categories ‘dissatisfied’ and ‘client avoidant or unmotivated’ into ‘client negative’ in their study.

The use of IPA as a method to analyse the interview data enabled the experience of dissatisfaction to become visible through the prolonged engagement with and detailed analysis of the data, as well as by moving between the part and whole of texts in a hermeneutic circle (Smith et al., 2009). The thematic analysis of the comparatively thin survey data, on the other hand, only revealed elements of this experience. The survey data have been incorporated into the discussion as appropriate. While the therapists’ voices are missing in the following discussion and it is not possible to understand the rationale for their interventions, it is argued that it is still valuable to gain insights into the participants’ experiences.

6.4.1.1 Feeling confused

It is recognised that the initial phase of therapy is often characterised by a period of uncertainty. Totton (2009) argues that “from the moment they first enter the room, most clients are trying to work out what is expected of them and, generally speaking, to provide it” (p. 18). The socialisation into therapy can be helped by clear contracting and explanations about therapy. This theme represents the difficulties participants had of making sense of therapy because there was a tension between their implicit expectations and the therapist’s behaviour. This created confusion and a lack of safety for participants, and inevitably led to some participants considering whether they were the ones ‘getting it wrong’.

Rennie’s (1994) theory of clients’ deference in psychotherapy is helpful to explain the findings. Rennie’s (1994) study used Interpersonal Process Recall with 14 clients to explore their experience of a therapy session which had just finished. He found that client deference was an important aspect of the client’s experience, and identified eight properties. Four of the properties: lack of clarity about the therapist’s approach; concern about criticising the therapist; trying to understand the therapist’s rationale; and meeting the expectations of the therapist were highly saturated and are now discussed with respect to my findings.

Rennie (1994) found that it was problematic if the client and therapist were in conflict over the plan for therapy. A lack of clarity about the therapist’s approach was evidenced by John and Caroline, who felt that therapy was more like a chat.

Similar experiences have been reported in other client experience studies (Adler, 2013; Orcutt, 2013). It is recognised that using therapy 'to chat' might be important for some clients as a way of creating safety, but the absence of an explanation about what was happening was unhelpful to participants. A large-scale study of NHS psychological therapy services (n=184) in England and Wales to explore patients' (n=14,587) experiences of negative effects of therapy reported that "patients were less likely to report lasting bad effects of treatment if they felt they had been given sufficient information about therapy before it started" (Crawford et al., 2016, p. 263). The requirement to obtain informed consent is not news in therapy, and underpins the ethical frameworks of the two largest organisations representing psychological therapy in the UK (Couchman, person communication, February 2, 2016): the BACP (BACP, 2016) and the BPS (BPS, 2009). It is surprising, therefore, that several participants were confused about the agenda of therapy and expressed a lack of clarity about what the therapist was doing. It appears participants' expectations or preferences for therapy were not explored or met, for example Participant 18 reflected that the therapist did not explain therapy sufficiently. Despite some participants not being clear about their expectations or realising that they were emergent, they did have an idea about what they did not expect. This awareness has also been reported in other studies (Orcutt, 2013). This raises questions about how to proceed in therapy if the client has no clear expectations. The data indicate a need for therapists to explore these matters explicitly, as participants indicated that the goal element of the working alliance was not sufficiently addressed (Bordin, 1979). In terms of practice, this suggests that therapists need to agree with clients on a clear rationale for the work, and to engage in regular reviews with clients to make sure that their original or evolving needs are being met in therapy. Contracting is about more than 'terms and conditions', it includes agreement about how therapy should proceed, and the need for therapists to demystify the process is highlighted. There are, however, limits to the extent to which therapists can explain everything about therapy, and striking a balance between being transparent and not depriving clients "of their experience" (Rake & Paley, 2009, p. 287) is an ongoing challenge for therapists.

Rennie (1994) theorised that a concern about criticising the therapist arises from a combination of self-doubt and politeness. Concerns about criticising or challenging

the therapist can be read in the interview data. Rather than expressing their concerns, some participants felt responsible for their dissatisfaction in therapy and did not seek clarity from their therapists. Self-blame has been identified in other PT studies (Adler, 2013). Politeness was a key object of concern in all interviews, to varying degrees, and points to the need for therapists to 'give permission' to clients to break with 'etiquette' if they feel confused about therapy. From a practice perspective, it is suggested that therapists point out at the start of therapy that therapy is not like other relationships clients may have, and they do not have to worry about 'hurting the therapist's feelings' by questioning the therapy itself.

Rennie (1994) found that the client's motive for understanding the therapist's rationale was to attune to the therapist. This was also evident in the data, for example John's confusion was evident in "what was all that about?" Participants also indicated that they felt under pressure to meet the therapist's expectations, for example Sophie recognised that she tried to be a good client and "was almost trying to second guess the answer that she wanted me to come up with". Caroline dutifully drank her tea and chatted about her week, and Emma rationalised what was happening in therapy by acknowledging that she has "a tendency to go along with things". This finding fits in with other studies which report clients' struggles to be 'good' clients (Dickson, 2015), and reminds therapists of the need to attune to clients.

Rennie's (1994) theory could be applied to all therapy experiences. However, the findings indicate that when some clients are *dissatisfied* with therapy, their confusion does not abate sufficiently to permit engagement in therapy, and they 'perform' until they decide to drop out. While Adler's (2013) study did not illuminate the trajectory of dissatisfaction, it did report themes such as lack of understanding, the authority of the therapist, and self-criticism. This 'performing' aspect of clients' behaviour has not been identified in other PT studies and makes an original contribution to understanding clients' experiences when they are dissatisfied. It is possible to identify two key dimensions to this experience. First, the client is confused within sessions, and second, the client thinks about the therapy itself rather than why they are in therapy. This knowledge opens up the possibility for the therapist to explicitly ask clients about these matters on a regular basis to check whether therapy is on track. I suggest that asking a question such as 'I'd like to check out how therapy is

going: does anything feel confusing to you about therapy?' may feel a lot less challenging to clients than asking 'how do you think we are getting on?' It offers the potential to enter the client's experience 'sideways', and mitigate client deference to the therapist. Relatedly, asking the client 'how much time in the sessions do you spend thinking about how to use the session?' could also give a non-threatening 'sideways' insight into the client's overall experience.

6.4.1.2 Losing hope

Expectancy is identified as one of the four factors influencing client change and is considered to contribute 15% of the variance (Lambert & Barley, 2001). The interview data indicate that participants' experiencing moved from feeling confused to losing hope, and a recognition that therapy was not going to meet their needs or expectations. Underlying this process was an evaluation of the therapy and the therapist.

The data indicate that the task element of the working alliance was not sufficiently addressed (Bordin, 1979). Poor topic agreement has been associated with PT (Adler, 2013; Orcutt, 2013) and this was present in the data, for example Sophie's therapist dismissed subjects that Sophie wanted to discuss. This finding reminds therapists to work with what the client brings and to explore the significance of their material. Some participants discovered that the modality of therapy was unsuitable. The recent study by Khazaie et al. (2016) found that the availability of free psychological information, for example on the Internet, influenced the decision to drop out of therapy because the therapist's advice was considered to be repetitive. The therapist's expert power base was diminished (French & Raven, 1959), and the influence of extratherapeutic factors did not help the client to improve (Asay & Lambert, 1999), but merely to decide that they were unprepared to invest in therapy. In other studies clients have perceived "therapy as of no benefit" (Acosta, 1980, p. 441), or experienced the therapist as repeating what they already knew (Orcutt, 2013). The data are consistent with these studies. Participant 16 felt that the therapist was simply "taking me through a workbook I could have done independently". Caroline also felt disappointed with the gains from therapy as she reflected, "you can't do 100 hours of therapy and come out none the wiser". These findings indicate that in order to sustain relevance, particularly in the digital age where alternatives to face-to-face therapy are being developed (Convey, 2016),

therapists needs to *add value* and provide something to clients that they are unable to achieve alone. From a practice perspective, this highlights a need for therapists to actively check with clients whether their interventions are helpful, for example it is suggested that clients would be able to comment on whether they find completing workbooks during therapy sessions helpful.

The findings indicate that inappropriate and confusing interventions were unhelpful. The inappropriateness of interventions (Participant 8, Participant 37, Caroline); the poor timing of interventions (Participant 30); and the inappropriate pacing of therapy (Participant 13) impacted on participants negatively, as has been found in other studies (Reynolds, 2001). Recently Wallace (2016) has questioned whether it is "more common than we acknowledge for accredited, experienced therapists in private practice not to follow what would generally be considered to be the basics of good clinical practice" (p. 6). The interview accounts lend some support to this challenging proposition, although the instances of dissatisfaction drawn from the survey data applied in other settings too. All interview participants and possibly some survey participants chose their own therapists, and some relied on the status and advertising of the therapist. The findings indicate that this was not always helpful because it created expectations which were not met. Participant 33 felt the therapist was "not as experienced as she claimed to be". This concern has not been reported in other PT studies and makes an original contribution to the literature, and is significant not only in terms of advertising standards but also in terms of the integrity of the profession. From a practice point of view, this highlights a need for therapists to be clear and explicit about their qualifications and experience. Therapists need to take into account that clients do not share their insider knowledge about terminology.

There are a number of reasons why the working alliance fails to develop. However, Asay and Lambert (1999) recognised that "the problem may justifiably be laid at the feet of the therapist who is lacking in maturity, skill, or interest, rather than reflexively attributing the failure to the client" (p. 48). Referring to the bond element of the working alliance, they reflected that it is of concern that therapists "fail routinely and persistently to offer high levels of empathy once they are not monitored" (Asay & Lambert, 1999, p. 48). Mearns and Thorne (2013) also suggest that person-centred counsellors may not necessarily improve with experience.

John's account offers some support for these views, as he wondered if therapists had the authority to behave in a particular way when they "reach a certain level". Despite his therapist being highly qualified and experienced, he experienced her as persistently unempathic. Emma reported a similar experience with her highly qualified and experienced therapist. These findings emphasise how important it is that therapists remember that it may be the first time clients have disclosed their stories, and that they may be monitoring the therapist's reaction very closely. From a practice point of view, this highlights a need for therapists to consider their own contribution to the therapy process rather than attributing any difficulties in therapy to client factors.

The research about PT recognises how critical the therapeutic relationship is. A poor therapeutic relationship has been characterised in numerous ways, including an inappropriate level of challenge (Orcutt, 2013), an inappropriate contribution by the therapist (Lippman, 1983); a lack of care (Moras, 1985), feeling uncomfortable (Papach-Goodsitt, 1985), a lack of empathy (Reynolds, 2001), a lack of interest (Chatfield, 2013), therapists' non-verbal behaviour (Boghi, 1965); feeling unheard (Knox et al., 2011); and not allowing the client to leave when they want to (Orcutt, 2013). The data confirm the importance of the therapeutic relationship. Participant 30 explicitly referred to the "lack of relationship", while others reported more general expressions of a poor relationship, for example feeling uncomfortable, a lack of empathy, and not being able to trust the therapist. The interview data reveal that the performative quality of the therapy for some participants prevented any relational depth developing. The uncertainty about the therapeutic relationship was exemplified in Sophie wondering, "I would have thought she was in tune enough to have felt that something wasn't working in that session". She wanted "the basics" in her therapy, someone to listen to her and bear witness to her story. It emerged that these basics were missing in the accounts of dissatisfaction, and were also absent in Orcutt's (2013) study. Some participants felt that the matching was not good. John recognised that he got on with his therapist and that they communicated well. He did not consider this to be therapeutic though, as the focus of the work had not been agreed upon. These findings remind therapists to retain a focus on why the client is in therapy.

Research conducted to explore clients' perceptions of what helped to strengthen the therapeutic relationship, indicated that acts of kindness, for example offering clients tea and biscuits, were helpful (Bedi, Davis, & Williams, 2005). Caroline referred to her therapist as kind, and doing things that she thought might help, for example making her tea and giving her cream to alleviate symptoms that did not exist. This indicates that a kind manner can also be experienced as unhelpful. Indeed Epstein (1994) suggests "this type of behaviour tends to detract from the seriousness and purpose of the therapy" (p. 214) and may signal that "this is just like any other relationship you have been involved in" (p. 214). Given that Caroline remained in therapy for two years it is possible that her therapist's kindness made it difficult for her to leave therapy. The unhelpfulness of kindness has not been reported in other PT studies, and makes an original contribution to understanding the experience of dissatisfaction. From a practice perspective, this highlights a need for therapists to consider the impact of interventions they may perceive as kind on the client.

Several participants referred to feeling concerned about the therapist's manner. Walfish, McAlister, O'Donnell, and Lambert (2012) carried out a study with therapists (n=129) in private practice asking them to rate themselves as therapists. The findings indicated that the participants were confident in their ability as therapists, with 25% believing that they were rated in the top 10% of therapists generally. This lack of humility is reflected in the findings. Sophie experienced her therapist as "God-like"*;* Alison and John felt that it would be the client's fault if therapy was unsuccessful; John felt injured by his therapist's ambivalence about him leaving; Alison and Olivia (therapy 2) felt told off by their therapists; and Participant 2 was dissatisfied with her therapist "coasting". Borghi (1965) found that the therapist *telling* the client how the client felt was unhelpful, and this was supported by the data. Therapists' assumptions were experienced as detrimental. Swift and Greenberg (2015) consider it important that the therapist displays 'expertness' in terms of offering hope, particularly at the start of therapy. However, Adler (2013) found that 'expertness' could restrict collaboration within therapy. The data indicate that therapist 'expertness' has the potential to create dissatisfaction if it is not used empathically throughout therapy.

6.4.1.3 Feeling disempowered by therapist

Feeling disempowered was a key aspect of some participants' experiencing, and has been reported in other studies (Adler, 2013; Orcutt, 2013). The therapist's perceived misuse of power intruded on the process of therapy. Beyond a lack of topic agreement in therapy, was a sense by some participants that the therapist was avoiding the issues they wished to work on because of a lack of knowledge. This was evidenced in "she [the therapist] tried to make out" that Alison had low-self esteem rather than work on issues of cultural identify. Participant 4 felt that her therapist was "avoiding me or intimidated by my problem". This experience of therapist power, a sense of the therapist imposing an agenda to obfuscate a lack of knowledge, has not been reported in other PT studies, although other studies have identified a failure to follow the client's agenda (Knox et al., 2011). This finding makes an original contribution to the literature about the experience of dissatisfaction in PT. This finding highlights a need for therapists to be transparent about their interventions and check that they are meeting clients' needs.

Some participants felt disempowered by their therapists' self-disclosures about their private lives. Self-disclosure by the therapist is a contested subject, and is inevitable through the physical aspects of the therapist, as well as their environment. In a review of the empirical literature, a diverse rationale for therapist self-disclosure has been identified, including: to encourage client disclosure; to model behaviour; to validate and normalise feelings; and to repair a rupture (Henretty & Levitt, 2010). It has been endorsed as a way of strengthening the therapeutic relationship through creating understanding, and addressing power inequalities (Knox, Hess, Petersen, & Hill, 1997). However, it is also recognised that self-disclosure carries the potential to be unethical and exploit the client "if the therapist is using that self-disclosure to get his or her own needs met by the client" (Peterson, 2002, p. 22). A distinction has been made between disclosures related to matters within the therapy session and disclosures related to the therapist's personal life. The latter may privilege the therapist's needs over the client's needs, and even create a role reversal in the therapy (Brown & Walker, 1990). Significant emotional harm can be caused to clients if they experience their therapist as exploitative in their self-disclosure, and it may be a precursor to more serious boundary violations (Epstein, 1994).

Mixed results have been reported in research exploring clients' experiences of self-disclosure (Audet, 2011; Knox et al., 1997; Wells, 1994). In the study by Wells (1994), positive effects such as gaining an alternative perspective were found, as were negative responses such as feeling concerned about the therapeutic boundaries as well as feeling disappointed and disillusioned. Participants in Audet's (2011) study felt that therapist self-disclosure helped to humanise the therapy, although concerns that this made therapy seem more like a chat or that a role reversal had taken place were also expressed. The data support the research findings which indicate that therapist self-disclosure is unhelpful. This is consistent with the findings of other PT studies (Dickson, 2015). The involuntary disclosure of 'therapist issues' derailed therapy for Participant 12, and Caroline was concerned that her therapist needed therapy more than she did. Therapist issues intruding on therapy were also found to be problematic in other PT studies (Chatfield, 2013). As was found in Audet's (2011) study, Caroline and John experienced the repeated self-disclosures about therapists' private lives as a burden, and felt some kind of role reversal had taken place in therapy. Emma experienced her therapist's self-disclosure about her parenting style as hurtful. The only other study focussing on the experience of dissatisfaction in PT also found self-disclosure unhelpful and persistent (Adler, 2013). From a practice perspective, it is suggested that therapists check with clients before self-disclosing, or "offer to the client in a tentative manner" (Gubi, 2015, p. 34).

One of the most surprising findings was just how long some clients remained in therapy despite feeling dissatisfied. Other studies have found that clients can take some time to terminate therapy (Orcutt, 2013). Cognitive dissonance theory (Festinger, 1957) may explain this finding. Cognitive dissonance arises when contradictory thoughts exist simultaneously, and the theory holds that this dissonance is mitigated by rationalising beliefs (Talbot, 2009). It is possible that it took a while for some participants to 'cut their losses' after spending so much time and money in therapy, and there is evidence that some participants were very cautious about criticising 'expert' therapists. Alison recognised that she "thought things might change". Emma had invested a lot in therapy. Caroline's existing issues were reinforced in therapy, and diminished confidence in her experiencing. This was also reported in Chatfield's (2013) study. Other studies have found that clients remain in

therapy because their presenting problems persist (Moras, 1985). However, the fact that some participants remained and persisted in therapy also conveys a sense of just how hard they were trying to make it work, as well as how much belief they had in the therapeutic endeavour. The interview accounts indicated that the participants who experienced good aspects of therapy remained in therapy for a longer period of time than participants who did not describe positive experiences of their therapy. The implication of this finding is sobering for therapists: just because a client remains in therapy, even for a long period of time, does not necessarily mean that the client is finding therapy beneficial. This finding raises questions about whether therapists could make it easier for clients to leave therapy, although care would need to be taken to minimise the potential for clients to feel "disposable", as John did. Such a proposition also highlights the need for therapists to pay attention to remainers who do not improve (Papach-Goodsitt, 1985). From a practice perspective, the need for therapists to assess clients' progress in therapy is highlighted (see section 6.6).

6.4.1.4 Impact of experience of dissatisfaction

Research has found that some clients feel worse and vulnerable after therapy, that they experience a loss of coping, and are less willing to try therapy in the future (Parry, 2015). Crawford et al. (2016) found that approximately 1 in 20 of IAPT patients reported lasting negative effects, and preliminary findings from an ongoing analysis of data collected from interviews indicate that these negative effects included: existing symptoms becoming worse; feelings of anxiety; feelings of anger; and a deterioration in self-esteem. The data offer some support for these findings. All interview participants reported experiencing an enduring impact from their therapy. This may be explained by an enduring attachment to their therapists, which is theorised to continue after termination (Obegi, 2008). Some participants experienced a loss of confidence in therapy, and feeling angry. Persistent negative feelings have also been reported in other studies (Chatfield, 2013; Knox et al., 2011), and anger was a major theme in Adler's (2013) study of dissatisfaction. Caroline felt that therapy "just gave me more stuff to deal with rather than relieving me of some of it". This is consistent with the findings of other studies (Orcutt, 2013). Olivia (therapy 1 and 2), Alison, and Emma also experienced negative effects, with Alison reporting that she felt traumatised. Similar findings were reported in Knox et al.'s

(2011) study. Additionally, some participants experienced a concern about other clients their therapists were working with, as well as experiencing feelings of guilt that they did not make a complaint. This is consistent with the findings of Symon's (2012) research about complaints in therapy. She found that clients felt guilty about not complaining about their therapy, and felt that "they potentially have a duty to speak out and to try and protect others" (p. 215). She also found that clients did not feel able to complain about their therapy because the impact of the experience was so severe that they needed to prioritise recovering from it rather than complaining about it. The data support this, and Alison felt that she had already suffered enough trauma. Although others encouraged John to complain, he did not want to and was concerned that doing so could be perceived as "sour grapes". This supports Symon's (2012) finding that clients felt they might be blamed if they made a complaint. From a practice perspective, this highlights a need for therapists to appreciate that PT is a serious matter for some clients and can have lasting consequences in terms of clients' wellbeing. This suggests that careful consideration of how to manage PT, if it occurs, is necessary (see section 7.3.2.1 for suggestions about how to manage PT).

Scott and Young's (2016) commentary on the Crawford et al. (2016) study points out that the study did not explore whether the therapist contributed to the negative experience. It is hard to justify not exploring the therapist's possible contribution to a therapy which fails to help, particularly given the importance of the therapeutic relationship in therapy. The data offer a contribution to understanding how participants experienced their therapists when they felt dissatisfied. Participants included the following concerns about their therapists: poor contracting and a lack of explanation about therapy; poor relationship skills; adopting an 'expert' position; misusing power; inappropriate self-disclosure; therapist 'issues' intruding on therapy; therapist acting like a friend rather than a professional; a sense that therapists were working beyond their level of competence; looking 'good on paper' not translating into adequate performance; coasting in therapy; and making assumptions. Apart from 'looking good on paper', the other concerns have been present in other PT studies (Adler, 2013; Chatfield, 2013; Orcutt, 2013). The therapist diagnosing people outside the therapy room was raised as a concern by Emma, and this has not been reported in other PT studies. These last two findings make an original contribution to the literature about the experience of PT. From a

practice perspective, there are a number of issues for therapists to consider in terms of how their way of working and manner can impact on the progress of therapy.

6.4.2 Client becomes unable to continue therapy

6.4.2.1 Client willingness to pursue therapy

The transtheoretical model of change (Prochaska et al., 1992) offers a framework to partially understand this theme. Prochaska et al. (1992) identify a lack of motivation, resistance, being defensive, as well as limited relationship skills, as being client factors implicated in the limited success of therapy. They also refer to the poor relationship skills of the therapist, as well as therapists' lack of technique and theory as contributing to poor outcome. The transtheoretical model recognises that clients frequently cycle through the different stages of change, which are identified as precontemplation, contemplation, preparation, action and maintenance. While this model was developed in the field of addiction, it is useful to explain the finding that participants were unwilling to pursue therapy. It can be used to explain how clients who begin therapy and are considered as 'prepared for action' do not necessarily remain in therapy because the shift "from thinking about their problems to doing things to overcome them" (Prochaska et al., p. 1106) does not occur. The model differentiates between entering therapy and therefore 'preparing for action', and remaining in therapy and therefore 'taking action'.

Reynold's (2001) study reported the incidence of PT because therapy was experienced as 'too much'. The survey data support this and found that some clients were unwilling to continue in therapy because they were not ready to do so. It was also found that this could be understood retrospectively. Wilson and Sperlinger (2004) found that some clients later realise that therapy may have been more helpful than they originally thought. The data from Sophie support this. However, a new aspect to this experiencing was identified. Participant 20 reflected that "at the time I was unaware of this and I decided that I didn't like the therapist's approach". This finding supports Westmacott and Hunsley's (2010) proposition that clients do not always know why they are terminating. The reframing of the original reason given for discontinuation has implications for the findings of existing research, as well as the findings of this study and reinforces the need to view the findings as insights rather than 'truths'.

The finding that PT could be seen as a developmental process fits in with some other studies. Dickson (2015) reported that participants felt "a sense of autonomy and self-assuredness" (p. 29), and Wilson and Sperlinger (2004) viewed PT as a 'shopping around' experience. Other studies have reported that PT helped clients to decide how they would use therapy in future (Orcutt, 2013; Wilson & Sperlinger, 2004), or to take responsibility for feeling better (Chatfield, 2013). It could be argued that by contemplating whether 'not complaining' gave his therapist permission to use the therapy space in the way she saw fit, John was able to examine an opportunity to express his needs. It could equally be argued that this might be impossible for a vulnerable client. Unlike Parry's (2015) study, nearly all participants did go on to have successful therapies elsewhere or would consider seeking further therapy despite some participants feeling harmed by therapy. This finding has also been reported in several other studies (Dickson, 2015; Orcutt, 2013; Papach-Goodsitt, 1985), although as in Orcutt's (2013) study, the data indicate that having to 'start over again' was experienced as unhelpful. From a practice perspective, the need to ask clients about their previous experiences in therapy at the start of therapy is highlighted, and may help to address the specific needs of clients.

6.4.2.2 Considering environmental factors

Environmental factors are reported in a number of other studies as influencing PT (Bados et al., 2007; Garfield, 1963). Orcutt (2013) found that these were of secondary importance, but in the present study there were of primary importance for the individuals affected. Participants spoke about two types of environmental factors which intruded on therapy: financial and service factors.

Financial considerations were crucial for some participants, and no longer being able to afford therapy prevented some participants from remaining in therapy. This finding has been reported in other studies (Pekarik, 1983b). This was not a straightforward issue, and the data indicate that some clients wanted to remain in therapy, and felt distressed. Participant 3 referred to a "strong attachment" to her therapist. This dilemma has not been reported in other PT studies, and makes an original contribution to the literature about the experience of PT. The data indicate that therapists offered reduced fees as far as possible but there was a limit to this. This raises questions about how clients can be accommodated or referred to low cost or free services when they run out of money, as well as how therapy is ended in such

cases to address the distress this may cause clients. From a practice perspective, this highlights a need to manage PT sensitively and to take into account clients' ongoing needs for therapy.

Swift and Greenberg's (2015) theory of PT maintained that clients carry out a cost benefit analysis when evaluating therapy, and other studies have reported a similar process (Chatfield, 2013). The data support this but these findings are limited to settings where clients pay for therapy. Participant 14 described a weighing-up process and was not willing to continue paying for a therapy that was not working. This prevented the rupture in therapy being repaired, and implies that some clients are unwilling to pay to repair ruptures in therapy. Participant 27 wanted the opportunity to have a discussion with the therapist without charge. These financial issues have not emerged in other PT studies and make an original contribution to the literature about the experience of PT. From a private practice perspective, these findings raise challenging questions for practitioners who charge for their services. The data suggest that a lack of progress in therapy made it less likely that a client would remain in therapy to repair a rupture. The rupture was the necessary trigger to leave. This offers support to Fray's (2000) finding that a negative experience in a session may be the impetus to leave therapy, and to views that therapeutic impasses (Petersen, 1998) or misunderstandings (Rhodes et al., 1994) can lead to PT. Money was mentioned in all interview accounts, and while affording therapy was not foregrounded, a desire to receive 'value for money' was evidenced by some participants. This recognises that the client is a consumer of services, and possibly reflects the influence of the Internet as well as other resources in terms of informing clients about therapy. This could also signal a move away from clients' deference to therapists. From a private practice perspective, these findings also highlight that financial issues are not simply an 'environmental issue' outside the remit of the therapist, they are a relational issue.

The introduction of the IAPT programme in 2006 put the need to offer accessible psychological therapy services on the agenda in England. It was disappointing, therefore, to find that service factors intruded on therapy to the extent that participants felt conflicted. Participant 26 did not feel that her therapy was client-focused, and Participants 1 and 11 experienced difficulties making appointments. While some of these issues are not under the control of therapists, it may still be

possible to minimise their occurrence. Similar issues were reported in Bein et al.'s (2000) study. From a practice perspective, the need for therapists to consider how 'user-friendly' their administration procedures is highlighted.

6.4.3 Communication about the premature termination

6.4.3.1 Client decides to leave therapy

Participants' decisions to prematurely terminate therapy were an expression of their power. The literature concerning power in therapy has largely focused on the power of the therapist. Therapy can never be 'power neutral' because of the help-seeking nature of the work and the power invested in the role of the therapist, but "the more aware we are of our own issues of power and those of our clients, the better therapy will work" (Totton, 2009, p. 16). The therapist's power can be theorised to include reward, coercive, legitimate, referent, and expert power, based on French and Raven's (1959) power bases. Some clients adopt a subservient role in therapy which reinforces the therapist's power (Harrison, 2013), and even if clients recognise that they are not powerless, they may submit to the therapist's power by virtue of the therapist's knowledge (McLeod, 2003). Zur (2009) challenges a view that compares therapy to parenting where clients are portrayed as "powerless, vulnerable, child-like beings" (p. 160). The data indicate that some clients acknowledged they were exercising power. For example, Sophie reflected, "I think this was me getting my power back" and "that sense of getting my power back was very, very strong", and John was happy to say, "I'm going to look for a different kind of therapist".

The ways in which participants communicated their PT are consistent with other research. Being unclear about how to approach the topic of leaving therapy and feeling concerned about hurting the therapist's feelings have been found in other studies (Dickson, 2015; Orcutt, 2013). Caroline felt disempowered by her therapist's insistence that she was not ready to leave therapy and she attended a further four free sessions. She did not want to be perceived as ungrateful. Even though she tried to reclaim her power by saying she wanted to end, her therapist's expert power (French & Raven, 1959) endured, and Caroline enacted an ending drawing on her personal values. John was partially congruent with his therapist but recognised the inevitable power differential in "she had all the qualifications and I had nothing". He was also mindful of not wishing to hurt his therapist. Sophie also enacted an ending. The findings are consistent with the research which recognises that therapists have poor

insight into the client's process, and that clients hide their negative responses from therapists (Regan & Hill, 1992). Hunsley et al.'s (1999) study found that therapists are "unlikely to attribute termination to problems with the therapy or client dissatisfaction with the therapist" (p. 386). The data from Sophie confirm this. Not only did the therapist fail to recognise Sophie's dissatisfaction, but she thought that Sophie had appreciated her work in: "she'd obviously thought I was giving her a gift". The data, therefore, suggest that dropout rates reported by therapists are conservative. From a practice perspective, this indicates a need for therapists to critically evaluate their work.

The finding that clients made an excuse to leave therapy or left following a break in therapy has also been found in other studies (Orcutt, 2013; Wilson & Sperlinger, 2004), and suggests that PT is difficult for some clients to talk about. It could also suggest that clients feel powerless and fear being talked into remaining (Moras, 1985). Few participants regretted leaving and, as has been found in other studies, some wished they had left sooner (Orcutt, 2013). The finding that clients ruminated over a lack of closure has also been reported in other research (Dickson, 2015; Orcutt, 2013). There was evidence that not having a good ending was a matter of concern for some participants (Participants 14 and 9).

6.4.3.2 Therapist response to premature termination

No existing research explores how clients experience therapists' responses to PT, although it has been touched on in other studies (Dickson, 2015). No existing research explores how clients would have liked their therapists to respond to their PT. These findings make an original contribution to the literature about the experience of PT and to the literature about endings in therapy. The survey data report a range of responses including a caring and respectful response from therapists, with some indicating that clients could return in the future if they needed to. This has been reported as a positive experience at the end of therapy in other studies (Chatfield, 2013; Jung et al., 2013), and the data confirm this. The conflicts therapists face in trying to meet clients' needs emerge from the data. The BACP Ethical Guidelines (BACP, 2016) suggest that therapists show "respect for the client's right to be self-governing" (p. 2). While Participant 25 reported that the therapist "checked in with a phone call after 6 weeks to see if I was ok" and I have interpreted this as being caring, it is equally possible that others could view this as

intrusive. There was evidence from the survey data that therapists tried to repair ruptures, for example Participant 30 referred to the therapist encouraging her "to carry on and work through it". Participant 33 indicated that her power was respected in the face of the therapist's encouragement to continue in therapy, as reflected by "they had no choice but to accept my decision". The findings also indicate that the manner in which the therapist responded to the client's experience led to some participants feeling diminished, for example Olivia's (therapy 2) therapist blamed her for the failure of therapy. This experience of being blamed was also reported in Adler's (2013) study.

Several participants reported that they received no response from their therapists when they prematurely terminated therapy. This was also reported in Dickson's (2015) study. This is a matter of concern, has implications for risk, and has recently received attention in the UK where it has been suggested that all clients who drop out of therapy are followed up (Parry, 2015). There is little discussion of risk in the dropout literature. Saxon, Ricketts, and Heywood (2010) carried out a study in the UK using data collected in an NHS counselling service to determine whether risk measures predict dropout. Their findings indicated that clients with greater distress and posing a greater risk to others were associated with dropout. Following the study, the service introduced a policy of contacting clients who miss appointments.

From a practice perspective, the findings offer support for recommendations that therapists should contact clients who prematurely terminate therapy. The failure by some therapists to respond to the PT denied participants an opportunity to repair the rupture. Participant 24 wanted a better ending and expected "a willingness to hear the rupture" from her therapist; Participant 22 wanted the therapist "to address my disappointment"; and Participant 23 and Olivia (therapy 1) felt uncared for. The data suggest that expectations of therapists did not end at PT, for example Participant 19 felt that "he could have suggested other therapists". This expectation has not been reported in other PT studies, and makes an original contribution to the literature about the experience of PT. It is possible that for some participants the 'premature termination' was a test for their therapists. Symons (2012) found that clients "need a poor therapy experience to be acknowledged" (p. 243). This was also present in my data. Participant 29 wanted the therapist to acknowledge that the experience was "down to both of us", and Participant 30 hoped for an apology. These findings

highlight a need for therapists to remain in relationship with clients at the point of PT and to manage this process sensitively. It is suggested that addressing how PT is managed in the contracting process may mitigate uncertainty for both parties if PT does occur.

6.5 Considering the impact of participants being therapists

For the interviews, homogeneity of the sample was determined by participants having prematurely terminated therapy for reasons of dissatisfaction. In studies where participants are hard to reach, the criteria for homogeneity are necessarily widened (de Visser, personal communication, May, 6, 2015). In my study there was one instance of PT before being a therapist (Olivia - therapy 1); four instances of PT while in training (Alison, Caroline, Emma, John); and two instances of PT while qualified (Olivia - therapy 2, Sophie). In line with other counselling research (see Symons 2012), for ethical reasons I did not ask why participants had attended therapy.

Only Alison and John explicitly spoke of having to attend therapy for their training courses. This does not exclude the possibility that Alison and John also attended therapy for other reasons. The literature regarding therapists' experiences of mandatory therapy indicates that the cost of therapy creates a burden (Kumari, 2011; Moller et al., 2009), and this was evident in John's account. Alison also mentioned cost but not to the same degree. A key factor differentiating Alison and John's accounts was that Alison wanted to focus on particular issues in her therapy, whereas John did not know how he wished to use therapy. It is likely that this created difficulties regarding engagement, as reflected in the literature (Kumari, 2011), and may have influenced his evaluation of his therapist's behaviour. Interestingly, both Alison and John went on to have further therapy which they found beneficial. This suggests that even though mandatory therapy may be experienced as unhelpful (Rake & Paley, 2009), it does not preclude further therapy being helpful. This may indicate that it is the experience in therapy which makes the difference, not the fact that it is mandatory.

All participants, except John, spoke of attending therapy for personal growth and/or personal distress, and this is consistent with the literature concerning the reasons why therapists attend therapy (Darongkamas et al., 1994; Daw & Joseph, 2007).

These are also reasons why other clients attend therapy (Carroll, 1996; McLeod, 2003). The unhelpful aspects of therapy reported in therapists' experiences of personal therapy were also present in my study, for example self-disclosure (Kumari (2011) and failure to meet expectations (Rizq & Target, 2010). In considering the impact of my participants being therapists, it is useful to compare my study of PT to Dickson's (2015) study of PT. Dickson (2015) used participants who were not therapists and reported similar detailed findings to my study which suggests that all clients can have similar experiences. However, what is interesting is the difference in the way accounts were presented. In Dickson's (2015) study, participants spoke of not matching to their therapist, whereas in my study participants evaluated their therapists critically and drew on ethical expectations. It is not possible to say how informed 'non-therapist clients' are about ethical frameworks. Further research in this area would be beneficial. It is possible that in studies using participants who are not therapists phrasing such as 'poor matching' could obscure the process of dissatisfaction; 'therapist clients' are able to draw on their insider knowledge (Rizq & Target, 2010). It is, however, important to bear in mind that 'non-therapist clients' have access to information about therapy via the Internet, and it has been reported that some clients feel that they are as knowledgeable as their therapists (Khazaie et al., 2016).

It is also useful to consider whether the quick response to my survey was because participants were therapists. Could this be because therapists are more critical about their experiences of personal therapy and their therapists than other clients, and wanted their voices to be heard? If so, this would suggest that my participants did not experience personal therapy in ways indicated by other studies in terms of recognising that therapy is not always like the textbook (Macran et al., 1999; Grimmer & Tribe, 2001). Further research could explore this. There is evidence that 'non-therapist clients' are also critical of and perceptive about their therapy (for example Sands, 2000). It is possible that the recruitment of participants was a result of the methodology and the advantage of using an online survey. Future research could assess whether this methodology could be used to engage other groups of participants.

In conclusion, the prevalence of mandatory therapy among therapists is a key difference between 'therapist clients' and 'non-therapist clients', particularly if the

client does not feel they have anything to work on. When comparing my study to Dickson's (2015) study, there are differences in how participants described their experiences which suggests participants had different expectations. However, in terms of the experience of dissatisfaction, many similar findings and feelings emerged, for example the unhelpfulness of therapist self-disclosure. It could be assumed that therapists would know what type of therapy they have received, yet two survey participants in my study did not know. It could also be assumed that 'therapist clients' would be more likely to be congruent with their therapists about dissatisfaction than other clients but this was not necessarily the case, as Orcutt's (2013) study also found. Further, in my study all participants experienced an enduring impact following PT, including Olivia in therapy 1, which suggests that dissatisfaction has the potential to impact on all clients. My conclusion is that the similarities between 'therapist clients' and 'non-therapist clients' outweigh the differences. From a practice perspective (see section 6.4.1.1) the findings suggest that therapists need to negotiate with 'therapist clients' how to use mandatory therapy in cases where the client is unsure how to use the therapeutic space, and to check out that therapy is meeting their expectations.

6.6 Informing practice

The findings are consistent with, and augment existing research. It is surprising, as well as a matter of concern, that what is generally considered to be 'best practice' in therapy was not experienced by some participants. For example, the importance of contracting and maintaining appropriate boundaries in therapy are recognised in professional ethical frameworks (BACP, 2016; BPS, 2009), and yet the participants did not feel these matters were given due attention and the working alliance failed to develop.

The findings suggest that in order to help improve practice, all elements of the working alliance need to be foregrounded, and that the relationship remains important even at the point of PT. It has been found that not only do therapists appear optimistic about how therapy is progressing, but that they rely on their personal judgement rather than the client's experience (Lambert, 2007). Given that it is the client who will decide whether they will prematurely terminate therapy, the need to understand how clients experience therapy is crucial. This could help therapists to understand how a particular client experiences an intervention, and

offers the potential to repair any ruptures which could sustain therapy (Safran, Muran, Samstag, & Stevens, 2001). The findings from research studies are often inconclusive, and paying attention to the individual experience of the client offers a way to tailor therapy to meet clients' needs. The findings from my study indicate that participants felt confused when they were dissatisfied, and uninformed about the rationale for their therapists' interventions.

It is suggested that using metacommunication can be helpful to understand clients' needs (Rennie, 1992). There are a number of formal ways in which therapists can assess client progress in therapy, for example by using the Outcome Questionnaire-45 (OQ-45) (Lambert, 2007). The Outcome Rating Scale (OCR) is an alternative to the OQ-45, and is often completed alongside the Session Rating Scale (SRS) which assesses the therapeutic alliance. The OCR and SRS are brief measures which can each be completed in under a minute (Miller, Duncan, Sorrell, & Brown, 2005). This makes "the process of collecting and using outcome data as user-friendly as possible for both therapists and consumers" (Miller et al., 2005, p. 200). Collecting and discussing these measures routinely with clients is one way of keeping therapy on track and delivering client-focussed therapy. They could also inform therapists whether clients had discontinued therapy because they had improved sufficiently (Hunsley et al., 1999). However, given what is known about client deference (Rennie, 1994), and clients hiding negative views (Regan & Hill, 1992), consideration is needed about how to collect feedback from clients who are dissatisfied with therapy. Typically, the awareness that a client is dissatisfied comes when the client prematurely terminates therapy (Hill et al., 1996). The data did not indicate whether any process reviews or measures were carried out. One possible way forward is to ask clients how they would prefer to give feedback, if they are willing to do so. For example, clients may find it easier to do so by email or post. Alternatively, an app could be developed to facilitate this. In addition, based on the findings, it may be helpful to explicitly check with clients at the end of each session whether they felt confused by anything the therapist did today, and to routinely ascertain what proportion of time clients spent in the session trying to figure out how to use the session. Based on the findings of my study, the answers to these questions could alert therapists to the existence of conditions which may indicate the presence of dissatisfaction.

6.7 Dissemination of the research

This research was disseminated at the Post-Graduate Research Conference in the Faculty of Social Science at the University of Chester in 2016. The feedback from practitioners was positive, and the methodology and findings were considered informative to their practice. I also developed a workshop for Professional Doctorate students at the University of Chester in using surveys in 2016. The feedback was positive, and attendees reported that they could apply the learning to their own practice and research. These activities demonstrate professional influence (Fulton, Kuit, Sanders, & Smith, 2013). Further dissemination is in progress, and I envisage writing a number of papers, presenting to relevant audiences, and developing a workshop for practitioners. I see this as a necessary and ongoing part of the research process (Reeves, 2015).

6.8 Summary

This chapter has discussed the findings with respect to the existing literature where possible, and reported the dissemination of the research. The next chapter will discuss the limitations of the research, and how the research could be developed. The significance of the research will be considered. A closing reflexive statement is also presented.

Chapter 7: Conclusion

I will demonstrate the relevance of the research in this chapter. Section 7.1 discusses the limitations of this research. Section 7.2 considers how the research could be developed. Section 7.3 summarises the answer to the research question, and offers some implications of the research to practice. Section 7.4 presents the original contribution to the field, and section 7.5 presents a closing reflexive statement.

7.1 Limitations of the research

The research provides a response to the question: *What is the experience of clients who prematurely terminate therapy*? It also addresses the aims of the study:

- To gain an overview of the experience of clients who prematurely terminate therapy;
- To understand the experience of dissatisfaction when this is given as a reason for prematurely terminating therapy;
- To inform and thus help improve practice.

While this study has provided insights into experiences of PT, it has limitations. The conclusions should be read in the light of these limitations:

7.1.1 Limitations regarding sample

- The small sample size means that it is not possible to generalise the findings of this study, although these findings may be transferable. The participants were qualified therapists, and it is possible that they would have specific expectations of therapy because of their understanding of the process of therapy. However, the stereotype of a premature terminator as someone who is poor at forming relationships is challenged by using therapist participants, given the requirements of therapy training. It could be argued that therapists are not representative of the wider client population. Some studies report that clients who prematurely terminate therapy have a low socio-economic status and are less educated (Wierzbicki & Pekarik, 1993). It is recognised that therapists are educated by virtue of their training. There are also limitations associated with the recruitment of participants online, for example, it excludes those who are not online, and may exclude certain populations (Gosling & Mason, 2015).

- It is possible that some survey participants referred to inpatient experiences of therapy. All interview participants referred to outpatient experiences.
- The limitations of self-report data are acknowledged, for example recall errors and narrative smoothing (Rhodes et al., 1994), however, the value of understanding clients' enduring experiences is recognised (Clarke et al., 2004). Three survey participants referred to experiences which occurred less than 12 months ago, and it is possible that insufficient time had been allowed to process these experiences.
- It could be argued that focussing on clients' experiences is of limited value because it fails to take account of therapists' perspectives. However, research indicates that therapists are poor at understanding clients' experiences (Westmacott et al., 2010). The involvement of dyads in research raises concerns about confidentiality, and possible harm to clients.

7.1.2 Limitations regarding methods

- The use of a survey restricted the interaction with participants. While I did ask 'what does this mean?' while coding the data and developing the thematic analysis, it was not possible to check this out or develop the accounts with participants. However, the use of the survey was informed by the philosophical considerations presented in section 3.1, as far as this was possible. The wording of some questions could have been improved to illicit more detailed responses. A final 'cleaning up' question was missing from the survey. Although the response length was not restricted, the inclusion of bigger text boxes in the survey may have encouraged participants to respond more fully. Wider piloting could have avoided some of these problems.
- IPA has been criticised from theoretical as well as practical perspectives. Giorgi (2010) suggests that not only is IPA unclear about its commitment to phenomenology, but that the methods are too flexible. IPA's methodology is clearly laid out in Smith et al.'s (2009) book in a detailed way, and the theoretical underpinnings are discussed including the layers of reflection possible in phenomenological research. It is argued that flexibility in the application of the method respects the researcher's interpretation. IPA has been criticised for using small sample sizes, although this enables a rich and detailed analysis of the phenomenon to be carried out (Smith et al., 2009). A

further criticism of IPA studies is that the influence of interviewer's contributions is sometimes missing (Drew, Weinberg, & Geoffrey, 2006). The word count for this thesis limits the inclusion of my contributions but I have given examples in section 3.8.2, and I have endeavoured to make my interpretations clear in the analysis to reflect the co-constructed nature of the findings.

- It is possible that a different researcher would have developed different interpretations of the data and themes. I have attempted to be transparent about my interpretations and have been reflexive throughout the study (see sections 1.5 and 3.8 and Appendix 10).

7.2 Further research

Further research to improve understanding of PT could be carried out as follows:

- Research could be carried out with different client samples including populations not online and those who may have been excluded from this research.
- Research involving clients could be carried out focussing on specific therapy settings; presenting problems; and modalities of therapy.
- It would be useful to ascertain clients' views about the management of PT from a larger sample.
- The research could be extended by eliciting therapists' views on the issues raised in this study.

7.3 Significance of the research

7.3.1 Answering the research question

This thesis has argued that in order to understand PT and dissatisfaction with a view to improving practice, it is necessary to explore clients' experiences in detail. Little PT research has explored clients' experiences in depth outside the USA, and no PT research has explored the experience of dissatisfaction across a range of therapies. An online survey and interviews were used to explore these experiences, and the findings were analysed inductively. The use of thematic analysis and IPA to analyse the data fitted with the research question and the aims of this research, and were applied in ways consistent with the tenets of the constructivist-interpretivist paradigm.

Bearing in mind the limitations of the research, dissatisfaction was a significant theme in participants' experiences of PT. Underpinning the experience of dissatisfaction was a poor working alliance, and Bordin's (1979) theory of the working alliance facilitated an understanding of the data. The rich data illuminated how the alliance failed to develop. The power exchange between the therapists and participants was made visible, and Rennie's (1994) theory of client deference helped to make sense of participants' experiences. Participants' experiences involved a period of 'waiting for things to get better' before losing hope in the therapeutic endeavour. This indicates that therapists have sufficient opportunity to intervene to get therapy 'back on track' *provided* they become aware that the client is feeling dissatisfied. The failure to get therapy 'back on track' maintained participants' confusion and a 'performance' rather than engagement in therapy. How long this 'performance' continued depended on client factors, with some clients remaining in therapy for a significant period of time. The detailed, inductive, interpretative analysis of the interviews has provided insights into participants' struggles to make therapy work, as well as how self-blame and/or helpful aspects of therapy acted as mechanisms to retain some participants in therapy. This research builds on Adler's (2013) study of the experience of dissatisfaction. Adler (2013) identified some similar themes, for example power struggles, but this research offers an understanding of the trajectory of dissatisfaction and illustrates how therapy was 'performed' by participants. This aspect of client behaviour has not been reported in other PT studies. These findings may be transferable, and understanding this experience could alert therapists to conditions and/or behaviours suggesting the presence of dissatisfaction. The findings suggest an experience of dissatisfaction closely allied to a model of grief (for example Kübler-Ross, 1969), moving from denial to acceptance.

Swift and Greenberg's (2015) conceptualisation of PT in terms of costs and benefits was also useful to make sense of the data and answer the research question. The requirement for therapy to 'add value' was an important consideration in clients' experiences of prematurely terminating therapy. The need for therapists to take account of the socio-economic climate in which therapy takes place was highlighted. Increasingly clients can access psychological resources online. Using therapy to regurgitate this material can be experienced by some clients as a waste of time and/or

money. This study builds on Khazaie et al.'s (2016) research by including the client experience of 'just' being taken through a workbook by the therapist. The need for therapists to check out with clients how they wish to use therapy, rather than imposing well-practised ways of being is highlighted in the research. Certain financial issues which have not emerged in previous PT research were raised, and indicate that financial issues are not just part of 'environmental' concerns and, therefore, beyond the influence of therapists. Becoming unable to afford therapy and feeling distressed about this, as well as not being prepared to pay for sessions in order to work through a rupture in therapy or discuss the ending emerged. Further research into the questions raised by these issues would be informative.

The manner in which therapists handled PT was inconsistent, and was experienced as unhelpful by some participants. No existing research has been found which explicitly explores clients' experiences of how PT is handled by therapists, or what clients needs are at this point in therapy. This study, therefore, builds on existing PT research involving clients (for example, Orcutt, 2013), and these findings may be transferable. A number of issues emerged. Some therapists failed to respond when participants prematurely terminated therapy. While not all participants wanted to process an ending, others did, and some participants expressed a desire to repair a rupture thereby achieving 'closure' (Joyce et al., 2007). These participants experienced a loss of trust in therapy and the profession. That therapists failed to act in a relational way at a crucial point in therapy disrupts the dominant discourse about the importance of the relationship across all therapies (Lambert & Barley, 2001), and may have ethical implications. It could be argued that non-response is aligned with an ethical principle of valuing the client's autonomy, but it could also be seen as ambivalence, sloppiness, an exercise of power, or even a self-deception about a 'difficult client making a welcome exit'. My conclusion is that the therapist's management of how therapy ends is just as important as the management of how it begins, *regardless* of how it ends. The enduring impact of dissatisfaction was evident for some participants.

7.3.2 Implications of the research to practice

The following considerations are offered as points of reflection for parties who may have an interest in the research.

7.3.2.1 Practitioners

The importance of aligning with clients' experiences in therapy is highlighted, and some ways to achieve this were discussed in section 6.6. Utilising the strategies presented in section 2.1.2 may also be helpful. Significantly, this research alerts practitioners to the danger of making assumptions. Attendance in therapy by participants, even for a long period of time, did not equate to satisfaction with therapy. Considering this, alongside the finding that clients found it hard to discuss PT, suggests that therapists may need to consider how to make it easier for clients to discuss dissatisfaction and/or leave therapy if it is not meeting their needs. It may be useful for therapists to treat every session as if it could be the last session, and to reserve some space at the end of sessions for clients to voice any concerns about therapy.

It is suggested that therapists manage PT in a way which does not intrude on the client, but acknowledges that it has happened. This research indicates that the following could be helpful inclusions in therapist communications: acknowledging the ending; allowing an open door for clients to return; suggesting onward referral sources; acknowledging any mistakes and apologising; offering the opportunity to repair a rupture; and fashioning an ending. While offering a final session or telephone call without charge could create a possibility to process an ending and/or repair a rupture, it is suggested that this is discussed at the beginning of therapy to avoid misunderstandings.

Therapists are also encouraged to consider the following: the critical evaluation of the use of self-disclosure, and seeking permission from clients before self-disclosing; the impact of what they perceive as their kindness on the client; and the importance of giving a clear account of their professional experience to clients to avoid confusion.

7.3.2.2 Trainers

It is suggested that discussions about PT, and ways to manage PT are included in therapy training.

7.3.2.3 Clients

The evidence supporting the effectiveness of therapy is significant (Lambert, 2013). It is, therefore, regretful that clients leave therapy without experiencing its potential.

It is hoped that the findings of this research may encourage clients to discuss any reservations they may have about the way that therapy is proceeding with their therapists.

7.3.2.4 Professional bodies

The findings indicate that explanations of therapy are absent or poor when clients are dissatisfied, and that collaboration is also poor. It is suggested that continuing professional development activities and re-accreditation processes include a compulsory element of the 'basics' (Asay & Lambert, 1999). Further, it is suggested that the possibility of developing a code of practice to manage PT is considered.

7.4 Original contribution to the field

- Few studies explore clients' experiences of PT in detail, and this study makes a contribution to the literature about clients' experiences of PT. No existing research has been found which explores clients' experiences of PT across a range of therapies and reasons for PT in England. Chatfield's (2013) study related to clients in secondary care with personality disorders; Eivors et al.'s (2003) small study related to clients attending an eating disorder unit with anorexia nervosa; Wilson and Sperlinger's (2004) study related solely to psychoanalytic clients; and Dickson's (2015) study related to clients who have attended at least six sessions and excluded PT related to environmental factors. This study makes an original contribution to the literature about clients' experiences of PT across a range of therapies and reasons for PT in England.
- Only one study has been found which has explored clients' experiences of dissatisfaction in PT, and this related to psychoanalysis in the USA (Adler, 2013). This study makes an original contribution to the literature about understanding clients' experiences of dissatisfaction in PT across a range of therapies.
- No research has been found which specifically addresses how clients experience therapists' responses to PT, although it has been touched on in other studies (Dickson, 2015). This study makes an original contribution to understanding clients' experiences of therapists' management of PT across a range of therapies and reasons for PT.

- No existing research has been found which explores how clients would have liked their therapists to have responded to their PT. This study makes an original contribution to understanding clients' needs at the point of PT.
- The methodology used to research clients' experiences of PT in this study is original and makes a contribution to research methods in therapy.
- Some clients' experiences reported in this study have not been found in other client experience studies of PT and make an original contribution. These findings may be transferable, for example: therapist kindness was experienced as unhelpful; a therapist-led agenda was experienced as obfuscating a lack of knowledge; a therapist 'looking good on paper' not experienced as translating into good performance; therapist diagnosing people outside the room was experienced as concerning; and client being unwilling to pay to repair a rupture.

7.5 Closing reflexive statement

I had to make a number of compromises in carrying out this research because of difficulties in recruiting participants. On reflection, the research design was ambitious for a thesis with such a limited word count, and I refined my question and aims throughout the study. This has been an important learning from carrying out this research. The limitations identified in section 7.1 will inform my future research projects.

Unexpectedly, some findings pointed to 'sloppy' practice, and made me question my own practice and reflect, 'do I ever do that?' The data had a significant impact on me; to read "I felt as though she was just trying to keep me attending for her benefit and not mine" (Participant 33) was troubling. I would feel that I had failed as a therapist if a client thought that about me. It was difficult to discuss some findings because I was aware that I did not have therapists' viewpoints too, and I was concerned about adopting a moral tone or indulging in what could be an ugly business of 'competitive ethicalness'. The findings have been interesting and important for my practice, for example I discuss PT when I contract with clients and how I manage this, and I talk about how dissatisfaction can develop in therapy.

Throughout this research I felt empathic towards the participants, and concerned about some of their experiences. I also felt curious about the missing voices, the therapists. I wondered if they had any sense of their clients' experiences, and I felt

empathic towards them too. I wondered how they thought they were performing as therapists and what they were basing their evaluations on. I also wondered about those not included in my study, the untold stories.

My views about PT changed during this study. Initially, I was curious to find out how I could improve my practice because I felt PT could be avoided. I now realise that this was informed by a socio-economic context of 'performance measurement'. In a culture which values measurement, audit, and cost reduction, it is likely that the measurement of dropout rates will become an important factor in evaluating therapist or service performance. Conflating dropout rates and poor performance ignores research which indicates that client improvement is also a reason for dropout (Acosta, 1980). Consensus about a definition of PT is desirable, and failing to address this may lead to therapists and/or services being undervalued. Focussing on a definition of PT based on achieving clinically significant improvement (Swift & Greenberg, 2015) fails to account for those clients who drop out of therapy when they could have made even more progress. The less we ask clients about their experiences, the less we know. Dropout is a story, not just a statistic. Now, I see PT as multi-dimensional: a positive expression of autonomy; developmental; a necessary choice; a rejection of therapy; a coping strategy; or a sign of dissatisfaction. I have learnt that how I manage PT as a therapist, if it occurs, has the potential to go some way to minimising distress. Researching participants' experiences of PT has deepened my understanding not only of PT, but of how valuable qualitative research involving clients is in uncovering new aspects in well-rehearsed conversations (Clarke et al., 2004).

The process of undertaking the Professional Doctorate has pushed my thinking in a number of ways. It has shown me that even when I think I am being reflexive or 'aware', there are blind spots and there is no escaping the 'person of the researcher'. Research supervision has been important in helping me to reflect on the 'impact of me' on this research, and to focus on the 'so what' of the findings. Participating in a research community and developing a network of fellow researchers have also been valuable in helping me to reflect on my ways of researching, and to learn from other students and academics. I hope to nurture this in my future research endeavours. I thought that the process would help me to find my voice as a researcher. I now

realise that is insufficient. I have to *use* that voice, respectfully. I feel my learning over the last six years has equipped me to do so.

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Appendix 1

Search strategy for literature review

The following databases were searched: CINAHL Plus with Full Text; MEDLINE; PsycARTICLES, PsycBooks, Psychology and Behavioral Sciences Collection, and PsycINFO using the following search terms:

1. Counselling OR counseling OR psychotherapy

AND

2. “no show” OR dropout* OR drop-out* OR “unilateral patient termination” OR “unilateral client termination” OR “patient unilateral termination” OR “client unilateral termination” OR “unilateral termination” OR “patient dropout” OR “client dropout” OR “patient drop-out” OR “client drop-out” OR “attrition” OR “early withdrawal” OR “early termination” OR “early treatment termination” or “premature termination”

3. NOT children OR child OR group OR family

A further search was run using 1 and 2 above and including the following search terms:

“client* experience*” OR “patient* experience” OR “client* perspective*” OR “patient* perspective*”

A further search was carried out for therapist experience of personal therapy using the following search terms:

1. "personal therapy”

2. counsellor OR counsellor OR therapist OR psychotherapist OR clinician

3. England OR Britain OR UK OR “United Kingdom”

Appendix 2

Participant information sheet for survey

Thank you for participating in my survey about your experience when you decided to prematurely terminate adult individual counselling or psychotherapy. For the purposes of this study, premature termination means that you decided to discontinue therapy before you had achieved your goals, and after having at least 2 sessions of therapy (including assessment appointment if given). This survey will take about 10 minutes to complete. My research is about therapists' experiences of premature termination of adult individual counselling or psychotherapy. The survey responses will be included in my doctoral thesis at the University of Chester, and may be included in other publications and presentations. Your contribution is anonymous and will be held securely. This means that once you have submitted your responses you will not be able to withdraw them. I will not collect your Internet Protocol (IP) address, and information collected will be encrypted. If you indicate at the end of this survey that you are interested in participating in an interview to discuss your responses further, and provide an email address, this will also be stored securely.

If participating in this survey feels difficult, please stop the survey. You can exit the survey at any point, but if you do not wish any responses to be included you will need to backtrack through the survey and delete your responses before exiting the survey. You do not have to answer every question.

If you feel that you wish to access further support, the following may be of help:

If you need urgent support it is possible to contact the Samaritans on 08457 909090. This service is available 24 hours, 365 days.

Alternatively, you can contact your GP to ask for support even if this is out of hours.

The following mental health charities offer telephone support:

Mind Tel: 0300 123 3393

Rethink Tel: 0300 5000 927 (local rate call)

Sane Mental Health Tel: 0845 767 8000

You can access a local counsellor or psychotherapist by visiting the BACP or UKCP websites.

If you would like to ask me any questions about my study please contact me.

This study is being supervised by Dr Peter Gubi, University of Chester.

Appendix 3

Participant consent statements for survey

1. I have read the participant information on pages 1 and 2 of this survey.
2. I have read and provide consent to participate.
3. I have read the above and I agree to information provided, including quotations, being used in the study. I wish to continue with this survey.

Appendix 4

Advertisement for research

Request for research participants: Counsellors and psychotherapists are sought to take part in a doctoral study about their own experience of prematurely terminating adult individual personal counselling or psychotherapy. This study has received ethical approval from the University of Chester. If you have previously ended therapy before your goals had been achieved, you can take part by completing a short survey (approximately 10 minutes) available online:

https://www.surveymonkey.com/s/ending

Thank you in anticipation. For further details, please contact

Appendix 5

Email inviting participants to interview

Dear _____,

Re: Research about experiences of prematurely terminating adult individual counselling or psychotherapy

Thank you for completing my survey for the above study, and indicating that you would like to participate in an interview.

I would like to meet you to discuss your experience of prematurely terminating therapy further. This interview would last about one hour and would be audio recorded. It would take place in a location that suits you, preferably a local university or library.

If you feel you would like to participate in such an interview, please let me know. I am attaching the participant information sheet and consent form for this stage of my research for you to read. Please contact me if you have any questions. If you are happy to proceed, please let me know so that we can arrange to meet at a location that is convenient for you, preferably at a local university or library.

I look forward to hearing from you.

Appendix 6

Participant information sheet for interviews

Therapists' perspectives on their experiences of prematurely terminating personal counselling or psychotherapy

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear, or if you would like more information. Take time to decide whether you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Little research explores why clients prematurely terminate therapy. It is likely that some clients would not be willing to give a reason for prematurely terminating therapy and this may reduce the reliability of this research. The aims of the research are:

- To understand how clients experience therapy
- To understand the decision making process of clients who prematurely terminate therapy
- To discover factors which hinder therapy
- To improve practice
- To contribute to the body of knowledge on premature termination from therapy

Why have I been chosen?

You have been chosen because you have indicated that you would be interested in participating in an interview.

Do I have to take part?

It is up to you to decide whether to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time

before data analysis begins and all data collected will be destroyed or returned to you if you prefer. I will inform you when I am starting analysis.

What will happen to me if I take part?

Before we begin the interview, I will go through the participant's information sheet and make sure that you understand what is involved. I will give you the opportunity to ask any questions you may have and clarify whether you wish to continue as a participant. I will talk to you about the consent form and answer any questions you may have. I will provide you with a list of sources of support in case you wish to access help to discuss any issues raised by participating in this research. If you are willing to continue, I will ask you to sign the consent form.

The aim of the interview is to find out about your experience of therapy, why you prematurely terminated therapy and how you make sense of this experience. I do not intend to ask you lots of questions, but I may use some open questions to assist with this process, for example:

- Could you please tell me about your experience of therapy?
- What sorts of expectations did you have for therapy?
- What did you find unhelpful about your therapy?
- How did you make the decision to terminate therapy prematurely?
- What stopped you from talking to your therapist about the unhelpful aspects of therapy?
- What could have prevented you from prematurely terminating?

We will meet for approximately one hour and I will audio record the interview. At the end of the interview, I will have a short conversation with you to talk about any issues that may emerge because of involvement in the research. The interview will later be transcribed and anonymised and any identifying information deleted. I will send you a copy of the transcript to review, and make any amendments if you wish. We will meet at a mutually agreed day and time and at a location that is convenient for you, preferably at a local university or library.

What are the possible disadvantages and risks of taking part?

There may be disadvantages or risks foreseen in taking part in the study. You may experience some strong feelings or distress during the interview. Please remember you can stop at any time. If you share with me that you feel suicidal, then I will encourage and advise you how to engage in services that can help you.

What are the possible benefits of taking part?

You may welcome the opportunity to share your views and experiences and to process your experience of prematurely terminating therapy. By taking part, you will be contributing to the understanding of clients' experiences of therapy through sharing your views, which may benefit clients in the future.

What if something goes wrong?

If something goes wrong, I will do everything in my ability to remedy any problem. If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact: Professor Annette McIntosh-Scott, University of Chester, Riverside Campus, Castle Drive, Chester CH1 1SL Telephone: 01244 511000.

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence (but not otherwise), then you may have grounds for legal action, but you may have to pay for this.

Will my taking part in the study be kept confidential?

All information collected about you during the course of the research will be anonymised and any identifying information will be omitted. My research supervisors and examiners may need to look at the data. If you disclose that you are involved in a serious crime and/or any child protection issues then I will have to break confidentiality and seek consultation on this matter. All data will be stored for 10 years in a secure filing cabinet, in line with the University of Chester's Research Governance Handbook. Thereafter, the data will be

destroyed safely. Any data sent electronically will be stored safely. My laptop is password secured and has up-to-date security software.

I will store your contact details and consent forms in a separate secure filing cabinet.

What will happen to the results of the research study?

The results will be included in a thesis for my Professional Doctorate and a copy of the thesis will be available in the library at the University of Chester and may be available electronically. I may use quotations from your contribution in my thesis. I may also use your contribution, including quotations, in other publications and conferences. The findings may improve the practice of counselling and psychotherapy. Individuals who participate will not be identifiable in my thesis or in any subsequent publication or presentation.

Who is organising and funding the research?

I am organising and funding my own studies.

Ethical approval

The Faculty of Health and Social Care Ethics Committee, University of Chester has approved this research. My principal supervisor is Dr Peter Gubi. If you have any concerns about the conduct of this research you can contact him on 01244 512040 or email p.gubi@chester.ac.uk

Whom may I contact for further information?

If you would like more information, before you decide whether you would be willing to take part, please contact:

Thank you for your interest in this research.

Appendix 7

Consent form for interviews

Title of Project: Therapists' perspectives on their experiences of prematurely terminating personal counselling or psychotherapy

Name of Researcher: Christine Bonsmann

Please initial box

1. I have read and understood the participant information sheet and have had the chance to ask questions ☐
2. I agree to the interview being audio recorded. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time before data analysis begins, without giving any reason. ☐
4. I agree to take part in this study. ☐
5. I understand that the data will be written up as part of a thesis and I will not be identifiable in the thesis. ☐
6. I agree to quotations from my contribution to this research being used in the researcher's thesis and subsequent publications. ☐
7. I have received some information about sources of support. ☐
8. I agree to read the transcript of the interview to ensure its accuracy, or to amend the data as appropriate. ☐
9. I understand that I will be contacted when data analysis begins, to be advised of the last point for withdrawing from the study. ☐

~~Name of Participant~~ ~~Date~~ ~~Signature~~

~~Researcher~~	~~Date~~	~~Signature~~

Appendix 8

Ongoing consent form for interviews

Ongoing consent form

Title of Project: Therapists' perspectives on their experiences of prematurely terminating personal counselling or psychotherapy

Name of Researcher: Christine Bonsmann

Dear Participant,

Thank you for your participation in my study so far, and for agreeing to read the attached transcript of our interview that I have anonymised. I have deleted identifying information.

Could you please indicate your agreement by initialling the statement below:

Please initial

1. I agree that anonymised extracts from the transcript you have sent to me can be used in your thesis and subsequent publications and presentations. _____

_____ _____ _____

Name of Participant Date Signature

Could you please sign and return this form. If you have amended the transcript, please return this too. Please keep a copy of this form. Thank you for taking part in this study. I am very grateful.

With kind regards and thanks,

Appendix 9

Sources of support for interviews

Sources of Support

- If you need urgent support it is possible to contact the Samaritans on 08457 909090. This service is available 24 hours, 365 days.
- Alternatively, you can contact your GP to ask for further support even if

this is out of hours.

- The following mental health charities offer telephone support:

  Mind Tel: 0300 123 3393
  Rethink Tel: 0300 5000 927 (local rate call)
  Sane Mental Health 0845 767 8000

You can access a local counsellor by looking at the BACP and UKCP websites.

Appendix 10

Extracts from reflexive journal

Example 1: Relating to carrying out the literature review

31.1.15

While carrying out the literature review I am surprised at how often participants in this area of research have been offered incentives to participate. Nuetzel and Larsen paid participants $30 per week – that's like having a job. Moras paid $10, Granley $9, Orcutt $25 and Bein study paid $15. I'm wondering how this may have influenced their studies if at all. Realising that even the process of carrying out the literature review is changing my practice.

Example 2: Relating to arranging the interviews

1.4.15

I have completely underestimated the complexity (and stress and cost) of arranging to meet interviewees, as well as the issues of having too many interviewees. The interviewees seem to be concerned about how far I have to travel. I wondered what impact this might have on the interviewees. Was their concern because, as therapists, they are naturally empathic? – or were they worried about justifying my journey by having 'enough' to say? Were they looking after me? Two participants offered to pick me up at the railway station, which I politely declined.

Example 3: Reflections from Sophie's interview

9.4.15

Carried out my first interview yesterday and felt very nervous. I did my best to stay close to her experience. I made sure I stated that I was meeting her as a researcher and not a therapist at the start of the interview. I was worried she might wonder what kind of therapist I was if I didn't engage in endless 'therapist' behaviours. Also worried I might slip into a role I am comfortable with because there are so many parallels between the research role and the therapist role in terms of skills required and meeting one-to-one etc.. I had made a conscious decision not to disclose my own experience of dropping out of therapy as a client. I had thought about this a lot – I didn't want to impose my voice on her experience. I had to strain to hear as the window was open and some noisy gardening work was going on nearby. I was very aware of adopting what Finlay calls an empathic openness to Sophie. I was also aware of continually reminding myself at various points 'this is not therapy, it's research'. This wasn't because I felt I was slipping into a therapist role in response to her material – it was more to do with an awareness that I was there in a researcher

role not a therapist role and I wanted to remind myself of this – to be reflexive about what I was doing or how I was being as far as I could be. I consciously caught myself noticing strong 'therapist' responses to her material at times and putting these aside. This was particularly loud when she was talking about the mutual friend she shared with her therapist. Staying close to her experience was a juggling act at times – I felt glad that I could draw on the skills I have learnt as a therapist of separating my issues from the client's issues.

Example 4: Reflections from Caroline's interview

14.4.15

It was clear that Caroline wanted to speak about her experience. She barely hesitated to get started. I got a real sense of her struggle in her therapy – it was exhausting to listen. I found it incredulous that her therapist worked with such little regard for boundaries. As she was speaking I kept having to consciously put aside my therapist self and remain with her experience. I found this very difficult as her account was so shocking. I realised that this experience is missing from the PT literature I have read. I had a felt sense of how difficult it would have been for Caroline to challenge her therapist. She clearly knew a lot about trauma and childhood sexual abuse and I wondered about how it must have been for her to have a therapist that didn't. I was aware of how Caroline was laughing throughout her telling despite there being nothing funny about what she was saying. My therapist self recognised how often clients laugh when they are talking about painful experiences – it felt like Caroline was doing the same. The experience she was describing was like a caricature of 'how not to do therapy'. Another major shock for me was how long she stayed in a therapy that she was finding so unhelpful – it was challenging to hear this and to put aside my expectations and personal experiences. The literature about how poor therapists are at recognising client dissatisfaction flashed into my mind.

Example 5: Reflecting on the impact on me of the interviews

21.4.15

I had clinical supervision today. I spent some time discussing the impact of the research on me and how I see my practice. I did not realise what an impact this has

had on me until I sat down and started talking about it. I felt contaminated by the stories of what I could only describe as poor practice. I talked about the changes I wanted to make to my practice – particularly in contracting – exploring how much clients can 'take on' at the beginning of counselling – needs to be ongoing and needs to take account of clients' deference - I also wondered whether any of my clients were remaining in therapy despite not feeling it was working – like Caroline – despite regular reviews. I am critically evaluating the potential 'lie' of the review process – potentially the therapist has 'ticked the box' and that's possibly exactly what the client has done too. How to achieve relational depth in the review given client deference issue?

Example 6: Reflection about participants' feedback regarding transcripts

6.5.15

I now have all the feedback. All were happy to continue and clarified questions I had about anonymising etc.. Olivia said that her first therapist was like Mrs Trunchball from the Matilda books – gives me a very vivid picture of her experience. John commented jokingly on the high level of 'errmms' in the transcript – now I wonder if I should have edited? Supervisor has already said quotes need to be edited because of limited word count for thesis – I wasn't convinced this would be 'authentic' – now I'm wondering. Seems as though John wanted the errmms taken out. Need to rethink this. I had always thought that editing quotes was inappropriate but now I'm seeing that there is a case for doing so.

Example 7: Reflection regarding analysis

5.9.15

I am busy analysing Sophie's interview (still) – I am finding the process of naming emerging themes difficult – the challenge is that a piece of text could be coded in a number of ways. I decide to code in several ways if I need to. I wonder about reading the interview for what Smith calls "gem" quotes – but I don't feel this is in

the spirit of an inductive approach. Surely “gems” will be included somewhere in the hermeneutic process.

Example 8: Reflection regarding analysis

6.10.15

Glad I went on the IPA course in Dublin – following Richard’s suggestions about how to bracket off the analysis of the previous interview – but feeling worried that some familiar themes have emerged – I couldn’t not remember them. However, new themes have emerged too – need to remember this is a cyclical process. Went back to the data to double check the themes are really there. Ironically, firming up the superordinate themes for interview 2 is making me anxious. I know I have come up with different superordinate themes to those from Sophie’s interview. I need to trust the process – it’s one thing to read it’s iterative and it’s quite another to actually embrace its complexity.

Example 9: Reflection regarding analysis

15.10.15

I am trying to remain close to each individual transcript but on some level I can’t unknow what I’ve already analysed - but listening to the audio and paying close attention line by line enables me to say close to each individual’s experience. I am also noticing that some themes overlap. I am going to live with this as the themes will be reconfigured when I carry out the analysis across all the cases.

Example 10: Reflection on writing my thesis

11.12.15

The process of drafting my findings is creating a further level of analysis – as I write and re-read passages. I am deciding where pieces of data I have coded in more than one way belong. This is seriously challenging. I am conscious of the ‘flatness’ of the written word and the poverty of removing text from context or the moments of

intersubjective meeting. Given that one quality evaluation for qualitative research can be 'did it move me in some way?' – I start to think about how subjective that is. What moves me may not move someone else! Constant process of asking myself 'why this quote and not that quote?' Constant process of asking myself 'am I answering my research question?'

Example 11: Reflection about attending research events

16.3.16

Attended BSA event about being an insider/outsider. Interestingly Matthews warns of 'feeling I'm inside and know everything'. Making me think. I am aware that I was aware of my 'fore-having' during the interviews and I tried to set this aside as far as possible, yet it's unlikely that I was entirely successful. I'm glad I chose IPA. It doesn't make out that the researcher is a distant observer – the double hermeneutic. There's a humanness about it that fits with my philosophy. Even when the other is not physically with us we are being-with-others. I have been taking my participants around with me.

Appendix 11

Audit trail: Analysis of Caroline's interview

Appendix 12

Caroline: Constructing superordinate theme: 'Feeling confused'

Theme	Data extract number	Key words	Page number in thesis
Subordinate theme: Therapy is a performance			

Hard to change established culture of therapy.	466	"It feels more like you're going along each week and just processing the last week rather than actually really doing anything in depth …"	78
Evaluating therapy.	473	"… that didn't feel that it was therapy, just felt like a bit of a chat really."	79
Client feels trapped	499	"I think I felt almost because I'd been going for so long I think I really struggled on how to say to her I'm, I'm finishing."	
Therapy is a performance	517	"I just kept trying to find anything and everything and I think I ended up talking about because I was, I'd done like my level 2 concepts and I was, I was talking about doing level 3 or something."	
Self in conflict	536-537	"… that was the worst part about it, not being able to be honest about what was going on in the room …"	
Self in conflict	557	"… I used to think no I don't, no that isn't."	77
Therapy is a performance	559	"… of course then I got all the, you know, well you'll, you'll feel this and you'll feel that and I never did, all I felt was relief."	
Therapy is a performance	581	"So we'd always have the saga of the cup of tea…"	78
Therapy is a performance	585-589	"You're only there 50 minutes. I'm sure you can make do without a cup of tea for 50 minutes."	
Therapy is a performance	594	"… she'd find out about my week and then that'd be it and I'd go …"	
Therapy is a performance	636	"… I just said to her OK yeah it's going very well, it's going fine. I think, not really knowing."	
Therapy is a performance	675	"I just gave her what I thought she wanted to hear."	
Subordinate theme: Diminishing the self			
Client has doubts about therapy	465	"… I started to feel a little OK, I'm not quite sure."	
Difficult to leave therapy	472	"So quite difficult to [pause] once I'd made that decision to actually leave, I found it difficult to leave."	
Client makes allowances for therapist	500-504	"… for someone else she could be a brilliant therapist."	81
Difficult to leave therapy	650	"On the top of probably 40 or 50 extra …"	
Client self-blame	656-657	"Is there something wrong with me that I can't do this?"	80
Client self-blame	661-662	"So I felt that I'd let myself down in therapy and I'd let her down in therapy …"	79
Subordinate theme: Experiencing good aspects of therapy			
Poor therapy has good aspects	563-564	"So that was a good thing that did happen within the therapy but apart from that it was all really quite tough going."	81

Appendix 13: Contextual information for survey participants*

Participant	Gender	Age	Number of experiences of therapy	Number of times prematurely terminated therapy	Type of therapy discussed in survey (i.e. last experience of PT)	Setting	Point of PT (if session number or time indicated)	Time elapsed since PT	Sought further therapy after last PT	Considered returning to PT therapist
1	F	31-50	>2	2	Psychodynamic	University	After session 3	<1 year	N	Y
2	F	31-50	1	1	Psychodynamic	Private Practice	After 10 months	>5 years	N	N
3	F	18-30	>2	>2	Integrative	Private Practice	After session 8	<1 year	Y	Y
4	F	31-50	2	2	Counselling	Private Practice	After session 6	1-5 years	N	N
5	F	51-70	2	1	Psychodynamic	Private Practice	After 2 years	1-5 years	Y	Y
6	F	31-50	>2	1	Humanistic	Private Practice	After 1 year	1-5 years	Y	N
7	F	31-50	>2	1	Psychodynamic	Private Practice	After 3 months	>5 years	Y	N
8	F	31-50	>2	1	Person-centred bodywork	Private Practice	Text	1-5 years	Y	N
9	F	31-50	>2	>2	Psychodynamic	Private Practice	Text	1-5 years	Y	N
10	M	31-50	>2	1	Gestalt	Private Practice	Text	1-5 years	Y	N
11	M	31-50	>2	2	Humanistic	NHS	After session 3	1-5 years	N	Y
12	F	31-50	>2	1	Humanistic	Private	Text	1-5 years	Y	N

						Practice				

Appendix 13 (continued)

Participant	Gender	Age	Number of experiences of therapy	Number of times prematurely terminated therapy	Type of therapy discussed in survey (i.e. last experience of PT)	Setting	Point of PT (if session number or time indicated)	Time elapsed since PT	Sought further therapy after PT	Considered returning to PT therapist
13	F	31-50	>2	1	Humanistic	Private Practice	After session 6	1-5 years	Y	Y
14	F	31-50	>2	1	Integrative	Private Practice	After session 14	1-5 years	Y	N
15	F	31-50	>2	1	Gestalt	Private Practice	After session 2	1-5 years	Y	N
16	F	18-30	>2	1	Cognitive Behavioural	NHS	After session 4	1-5 years	Y	N
17	M	31-50	>2	1	Psychodynamic	Private Practice	Text	>5 years	Y	N
18	F	31-50	>2	1	Humanistic	Private Practice	After session 6	> 5 years	N	N
19	F	51-70	>2	1	Not answered	Private Practice	After session 10	>5 years	Y	N
20	F	31-50	>2	1	Psychodynamic	Charity	Text	1-5 years	Y	N
21	F	51-70	>2	1	Integrative	Private Practice	After session 5	>5 years	Y	N
22	M	51-70	>2	1	Integrative	Private Practice	After session 4	1-5 years	Y	N
23	F	31-50	>2	2	Humanistic	Private Practice	After session 4	>5 years	Y	N

Appendix 13 (continued)

Participant	Gender	Age	Number of experiences of therapy	Number of times prematurely terminated therapy	Type of therapy discussed in survey (i.e. last experience of PT)	Setting	Point of PT (if session number or time indicated)	Time elapsed since PT	Sought further therapy after PT	Considered returning to PT therapist
24	F	31-50	>2	1	Integrative	Private Practice	After session 5	1-5 years	Not answered	N
25	F	31-50	>2	1	Humanistic	Charity	After session 6	>5 years	Y	N
26	F	31-50	1	1	Cognitive Behavioural	NHS	After session 2	>5 years	N	N
27	F	31-50	>2	1	Psychodynamic	Private Practice	After session 3	1-5 years	Y	N
28	F	31-50	>2	1	Psychodynamic	Private Practice	After session 4	>5 years	Y	N
29	F	31-50	>2	1	Integrative	NHS	Text	>5 years	Y	N
30	F	31-50	>2	1	EMDR	Private Practice	After session 2	1-5 years	Y	N
31	F	18-30	Not answered	Not answered	Humanistic	Private Practice	After session 8	1-5 years	Y	N
32	F	31-50	>2	1	Cognitive Behavioural	EAP	After session 5	>5 years	Y	N
33	F	31-50	>2	1	Humanistic	Private Practice	After session 3	>5 years	Y	N

Participant	Gender	Age	Number of experiences of therapy	Number of times prematurely terminated therapy	Type of therapy discussed in survey (i.e. last experience of PT)	Setting	Point of PT (if session number or time indicated)	Time elapsed since PT	Sought further therapy after PT	Considered returning to PT therapist
34	M	51-70	>2	2	Do not know	University	After session 3	>5 years	Y	N
35	F	51-70	>2	2	Humanistic	Private Practice	After session 5	1-5 years	Y	N
36	F	31-50	1	1	Humanistic	Private Practice	After 2 years	1-5 years	N	Y
37	F	51-70	>2	1	Psychodynamic	Private Practice	After session 2	>5 years	N	N
38	F	31-50	>2	1	Integrative	Private Practice	After session 4	<1 year	Y	N
39	F	31-50	>2	1	Humanistic	Private Practice	After 2 years	1-5 years	Y	N
40	F	51-70	Not answered	Not answered	Humanistic	Private Practice	After 18 months	1-5 years	N	N

Appendix 13 (continued)

* All participants were qualified therapists living in England.